

DEPARTMENT OF VETERANS AFFAIRS LEASES: IS THE VA OVERPAYING FOR LEASED MEDICAL FACILITIES?

(114-54)

HEARING
BEFORE THE
SUBCOMMITTEE ON
ECONOMIC DEVELOPMENT, PUBLIC BUILDINGS, AND
EMERGENCY MANAGEMENT
OF THE
COMMITTEE ON
TRANSPORTATION AND
INFRASTRUCTURE
HOUSE OF REPRESENTATIVES
ONE HUNDRED FOURTEENTH CONGRESS
SECOND SESSION

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September 23, 2016

SUMMARY OF SUBJECT MATTER

TO: Members, Subcommittee on Economic Development, Public Buildings and
Emergency Management
FROM: Staff, Subcommittee on Economic Development, Public Buildings and
Emergency Management
RE: Subcommittee Hearing on “Department of Veterans Affairs Leases: Is the VA
Over-Paying for Leased Medical Facilities?”

PURPOSE

The Subcommittee on Economic Development, Public Buildings and Emergency Management will meet on Wednesday, September 28, 2016, at 10:30 a.m. in 2253 Rayburn House Office Building to receive testimony related to the Government Accountability Office’s (GAO) report on Department of Veterans Affairs (VA) leasing for health care facilities and alignment of its practices with those of the General Services Administration (GSA). The Subcommittee will hear from representatives of the GAO, the VA, and the GSA regarding the findings of that report, progress and timing on the VA lease prospectuses to be submitted to the Committee on Transportation and Infrastructure (Committee) for approval, and how the GSA and the VA are ensuring the costs associated with the facilities are managed appropriately.

BACKGROUND

In 2003, the GAO placed real property management on its list of “high risk” government activities, where it remains today.¹ Real property management’s placement on the list is in part because of the federal government’s increasing reliance on leasing instead of federal ownership even though the GAO has shown that ownership is generally more efficient for large, long-term space needs. Despite this, the VA has increasingly turned toward leases to fulfill its facility needs for providing veterans with medical care. As a result, the Committee requested that GAO study the real estate practices of the VA to ensure that agencies growing reliance on leasing is justified.

¹ GAO, *High-Risk Series: An Update*, GAO-15-290 (Washington, D.C.: February 11, 2015).

The Committee specifically requested that the GAO conduct a review related to: (1) the factors that account for the VA's decisions to lease space for medical facilities; (2) whether the VA's cost-estimating is consistent with best practices; and (3) how the VA's leasing process aligns with that of the GSA.

Department of Veteran Affairs (VA) Leasing

The VA manages the largest health care network in the United States through the Veterans Health Administration (VHA). It has over 2,700 health care sites, including hospitals and outpatient clinics. In order to meet the health care demands and to keep pace with changes in health care technology and delivery, an increasing number of the VA's health care facilities are leased. Over the 10-year period from 2005-2015, the number of leased health care facilities grew 80 percent from 689 in 2005 to 1,246 in 2015. The outpatient facilities vary in size from under 20,000 square feet to over 200,000 square feet. Typically, given the nature of the facilities, new leased VA facilities are build-to-suit (built specifically for the VA's purposes and use) and have lease terms of up to 20 years.

The VA's leasing authority for leasing a medical facility can be found at Section 8103 of title 38, United States Code. However, pursuant to 38 U.S.C. §8104, leases exceeding \$1 million require congressional authorization. While the GSA had previously delegated authority to the VA under the *Public Buildings Act*, the VA never sought authorization for leases above \$2.85 million (the GSA's threshold for congressional authorization) from the Committee to authorize use of the GSA's leasing authority (40 U.S.C. § 3307).

In 2014, the Congressional Budget Office (CBO) estimated that the leases authorized in the *Veterans' Access to Care through Choice, Accountability, and Transparency Act of 2014*, would result in \$1.2 billion in direct spending.² This followed testimony by the CBO on June 27, 2013 concluding that the CBO viewed most leases of medical facilities by the VA as akin to capital leases and, therefore, the full costs of such leases must be recorded in full when the lease is executed.³ Questions were raised as to whether the VA was recording its leases appropriately pursuant to the *Recording Statute and Anti-Deficiency Act*.⁴ This also raised questions as to whether the VA had the authority to enter into long-term leases under its own leasing authority.

As a result, the VA began working with the GSA to use the GSA's leasing authority to help the VA acquire medical facilities.⁵ On July 24, 2014, the GSA entered into a new delegation agreement with the VA. Under the delegation agreement, leases exceeding \$2.85 million require Committee authorization.⁶ Six leases were submitted to the Committee for authorization and were approved by the Committee on September 17, 2014. Since that time, the Committee has not

² Congressional Budget Office Cost Estimate for H.R. 3230, Veterans' Access to Care through Choice, Accountability, and Transparency Act of 2014, July 10, 2014.

³ The Budgetary Treatment of Medical Facility Leases by the Department of Veterans Affairs, Robert A. Sunshine, Deputy Director, Congressional Budget Office, before the Committee on Veterans' Affairs, U.S. House of Representatives, June 27, 2013.

⁴ 31 U.S.C. 1341 and 31 U.S.C. 1501, respectively.

⁵ Letters to Chairman Shuster and Ranking Member Rahall dated September 12, 2014.

⁶ 40 U.S.C. sec. 3307.

received any new VA medical facility leases for approval. The Committee expects to receive eight prospectuses for the VA's leases exceeding the GSA's threshold in the near term.

While the GSA has long-term leasing authority, it must still follow the requirements of Office of Management and Budget (OMB) Circular A-11, Appendix B related to the Budgetary Treatment of Lease-Purchases and Leases of Capital Assets. The circular requires that if a lease meets the definition of a capital lease⁷, the full budget authority for the entire term of the lease must be allocated when the lease is executed. A capital lease is any lease other than a lease-purchase that does not meet the criteria of an operating lease. This OMB Circular A-11 requirement applies to both the GSA and the VA. As such, the GSA and the VA must ensure that VA leases are operating leases (which do not require the full cost upfront) and are not categorized as capital leases.

GAO Findings

The GAO found some areas where improvements have been made by the VA and where improvements are still needed – such as better transparency on the VA's preference for leasing and cost comparison data.

The VA Prefers Leasing: The VA established the Strategic Capital Investment Planning (SCIP) process to identify and assess capital needs starting with those included in the 2012 fiscal year budget submission. This process includes a gap analysis and assessment, long-range action planning and prioritization. During the SCIP process, the VA analyzes alternative solutions to meet space needs, including leasing and construction. The VA's preferred solution for new medical facilities has been leasing. The VA asserts that leasing is faster and provides flexibility should a facility need to relocate. While the VA considers costs in its process, project costs have a lower weight among the VA's criteria. The VA has also asserted that owned facilities would require a longer timeframe to open than a leased facility and would limit the VA's flexibility to adapt to potential changes in the veteran's population, demand for services, new technologies, or health care delivery. However, the VA has not provided congressional stakeholders with information that supports that reasoning. For example, the VA did not have the data and the ability to track leases in a way to determine if more flexibility was in fact achieved or needed. The GAO recommended greater transparency on data that can help assess whether the reasons for preferring leasing are founded and to better assess and compare the costs of leasing versus construction.

Cost-Estimating: The GAO also reviewed the VA's cost-estimating process for medical facility leases. The GAO concluded that the VA's cost-estimating process mostly met the characteristics for producing reliable cost estimates by addressing nine out of 12 best practices. The primary area where the VA fell short in the GAO's review was related to ensuring accuracy based upon

⁷ A capital lease is any lease other than a lease-purchase that does not meet the criteria of an operating lease. An operating lease is a lease where the ownership of the asset remains with the lessor during the term of the lease; is not transferred to the Government at or shortly after the end of the lease term; a lease that does not contain a bargain-price purchase option; has a lease term that exceeds 75 percent of the estimated economic life of the asset; have lease payments that do not exceed 90 percent of the fair market value of the asset; the asset is a general purpose asset; and there is a private sector market for the asset.

comparisons to market rates. While the VA includes a review of market rates in a given area, the VA then adds to those rates standard adjustments to account for building out medical space. The GAO concluded that the specialized build-out space may make full compliance with best practices for cost-estimating difficult. In addition, the GAO indicated that the VA does not follow-up to track the actual costs to develop lessons-learned to help inform its future cost-estimating process.

The VA Alignment with the GSA: The GAO indicated that the VA has made progress in working with the GSA. The GAO noted the VA expanded the training of its contracting officers, implemented an internal management review process to better manage the GSA delegations, and increased its coordination with the GSA. According to the VA's data, the average processing time for the VA's delegation requests fell from 58 days between July 2014 and February 2015 to 21 days between February 2015 and February 2016.

CONCLUSION

The hearing will focus on the GAO review, updates from the VA and the GSA on how their lease review processes are working, and the status of outstanding prospectuses to be submitted for Committee approval.

WITNESS LIST

Ms. Rebecca Shea
Acting Director, Physical Infrastructure
U.S. Government Accountability Office

Mr. James M. Sullivan
Director of Asset Enterprise Management
U.S. Department of Veterans Affairs

Mr. Chris Wisner
Assistant Commissioner for Leasing
Public Buildings Service
U.S. General Services Administration

**DEPARTMENT OF VETERANS AFFAIRS
LEASES: IS THE VA OVERPAYING FOR
LEASED MEDICAL FACILITIES?**

WEDNESDAY, SEPTEMBER 28, 2016

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON ECONOMIC DEVELOPMENT,
PUBLIC BUILDINGS, AND EMERGENCY MANAGEMENT,
COMMITTEE ON TRANSPORTATION AND INFRASTRUCTURE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:34 a.m., in room 2253, Rayburn House Office Building, Hon. Lou Barletta (Chairman of the subcommittee) presiding.

Mr. BARLETTA. The subcommittee will come to order. I want to thank the witnesses from the Government Accountability Office, the Department of Veterans Affairs [VA], and the General Services Administration [GSA] for being here today.

The purpose of today's hearing is to make sure medical facilities are delivered quickly and cost effectively so that our veterans can receive the medical care that they require. Now, the Transportation and Infrastructure Committee is involved because the Public Buildings Act requires all leases over \$2.85 million to be authorized by our committee and the Senate Environment and Public Works Committee.

Now, GSA can delegate this leasing authority to other agencies, but it cannot waive the requirement for congressional authorization. Providing quality health care to our veterans is my top concern. Our men and women in uniform put their lives on the line to protect our country and our freedoms. Medical facilities, whether owned or leased, are a critical part of delivering healthcare services. Unfortunately, the VA has struggled greatly to require health care facilities on time, on budget, and in compliance with the law.

The VA's new Colorado hospital is so far over budget and behind schedule that the Army Corps of Engineers has had to take over management of the project. And the VA's leasing program has been too slow and out of compliance with the Public Buildings Act and the most basic Government accounting rules.

Both the GAO and the VA inspector general have detailed a history of VA's mismanagement of its real estate. In fact, in a 2012 letter from the House Veterans' Affairs Committee to the VA, the committee expressed concerns about the ways that the VA's seven healthcare clinic leases passed in 2009. In 2013, the inspector general reported VA's management of timeliness and costs in the healthcare clinic lease procurement process has not been effective.

On top of all this, the Congressional Budget Office at OMB raised serious questions about how the VA has been accounting and budgeting for these leases. Unfortunately, as highlighted at our July hearing, many agencies with leasing authority, outside of GSA, do not understand the legal limits of their authority. We have seen agencies like the SEC and the Commodity Futures Trading Commission find themselves in serious trouble because of this. Exceeding the legal limitations can result in Anti-Deficiency Act violations, which have criminal penalties and significant project delays.

In 2013 and 2014, OMB raised serious questions whether the VA had, in fact, exceeded its leasing authority. As a result, the administration directed the GSA to step in. GSA must ensure the VA's leases are properly authorized and do not violate the Anti-Deficiency Act.

On September 12, 2014, the committee officially received a letter from the VA requesting approval of six leases for their healthcare clinics, recognizing projects over GSA's threshold of \$2.85 million required this committee's approval. The committee approved them 5 days later despite having to gather updated information to evaluate costs.

It has now been 2 years since this committee approved those six leases, and we have not received any new prospectuses for healthcare clinics since then. We understand there are eight additional leases requiring our authorization that were included among the 27 leases in the 2014 Choice Act. Because of this committee's role in approving these leases, the committee, along with the Veterans' Affairs Committee, requested GAO conduct a review of the VA healthcare clinic leasing.

Specifically, the GAO examined a few key areas. One, the criteria VA uses to determine whether to lease or own medical facilities. Two, the accuracy of VA's cost estimates for projects. And, three, how the VA is aligning its leasing process with that of the GSA.

Today, we want to hear what improvements have been made and what still needs to be done to make sure that the VA medical leases are cost effective and comply with the law.

We also want to receive updates on the previous six projects we authorized in 2014 and a timetable on when we will receive the additional eight. With all the issues the VA is grappling with to ensure our veterans are served in a timely manner, the VA should take full advantage of the opportunity to leverage GSA's real estate expertise.

I look forward to hearing more from our witnesses on these issues. Thank you.

I now call on the ranking member. Before that, I ask unanimous consent that Members not on this subcommittee be permitted to sit with the subcommittee at today's hearing, offer testimony, and ask questions. So be it.

And now I call on the ranking member of the subcommittee, Mr. Carson, for a brief opening statement.

Mr. CARSON. Thank you, Chairman Barletta, and thank you for your leadership.

Prior to 2014, the VA used their own real estate authority to sign leases for medical facilities. However, the VA in consultation with the Office of Management and Budget, later determined that it did

not have legal authority necessarily to enter into multiyear leases. The VA now relies on GSA's authority to execute these leases. In 2014, this committee approved six prospectuses submitted by GSA on behalf of the VA. These six medical facility leases were the first of their kind to be approved by the committee.

Now, typically, these facilities include mental health clinics, re-adjustment counseling centers, research, and other types of clinical spaces. Because the VA is working with the GSA to execute these leases, they have now come before this committee for approval. Although we approved the first six leases, Chairman Barletta and I and members of the Veterans' Affairs Committee thought it was appropriate to request GAO's study to the VA's choices in managing its real property assets.

While we want to support the VA's efforts to provide essential health care to our country's veterans, it is also important that this committee have some assurances that the VA is managing its real estate assets as efficiently as possible. Every dollar saved in a real estate transaction is a dollar that can be redirected to supportive services for veterans, an important priority for every Member of Congress.

I look forward to today's testimony from the VA, GSA, and GAO on how this program is being managed and how improvements can be made going forward.

Thank you, Chairman. I yield back.

Mr. BARLETTA. Thank you.

On our panel today we have Ms. Rebecca Shea, Acting Director of Physical Infrastructure Issues, Government Accountability Office; Mr. James M. Sullivan, Director of the Office of Asset Enterprise Management, United States Department of Veterans Affairs; and Mr. Chris Wisner, Assistant Commissioner for Leasing, Public Buildings Service, General Services Administration.

I ask unanimous consent that our witnesses' full statements be included in the record.

Without objection, so ordered.

Each of you is now recognized for 5 minutes. And, Ms. Shea, you may proceed.

TESTIMONY OF REBECCA SHEA, ACTING DIRECTOR, PHYSICAL INFRASTRUCTURE ISSUES, U.S. GOVERNMENT ACCOUNTABILITY OFFICE; JAMES M. SULLIVAN, DIRECTOR OF THE OFFICE OF ASSET ENTERPRISE MANAGEMENT, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND CHRIS WISNER, ASSISTANT COMMISSIONER FOR LEASING, PUBLIC BUILDINGS SERVICE, U.S. GENERAL SERVICES ADMINISTRATION

Ms. SHEA. Thank you. Good morning, Chairman Barletta, Ranking Member Carson, and members of the subcommittee. I am pleased to be here today to talk about GAO's review of VA's practices for leasing major medical facilities. VA operates the largest healthcare network in the U.S. with over 2,700 facilities, nearly half of which are leased. Many of VA's facilities are aging, and to replace them and expand access to veterans, VA has increasingly turned to leasing rather than construction and ownership to provide these important services to veterans.

Over the past 10 years, the number of medical facilities leased by VA grew to just under 1,300 facilities, 57 of these were major medical facility leases, spaces with average annual rent in excess of \$1 million.

Today, I will discuss our June 2016 report, the focused on factors affecting VA's decisions, cost estimating process, and alignment with GSA requirements.

Turning, first, to the factors effecting VA's leasing decisions, we found that VA leases major medical facilities, because leasing can more quickly result in a finished facility and because it provides VA flexibility to relocate at the end of the lease term, which is limited to 20 years. In fact, VA cited flexibility to move in all of its major medical lease proposals since 2015, including some in which VA estimated the construction of its own facility would be less costly.

According to VA, moving supports changing priorities such as meeting requirements for veterans access and changing security and compliance standards. As we have noted in our past work, disposing of federally owned facilities can be difficult, suggesting a certain level of support for VA's argument for this flexibility. However, VA does not assess whether or how it has actually benefited from this flexibility when justifying its leases.

In our June report, we recommended that VA annually assess how it has used the flexibility afforded by leasing and provide this information to Congress in its annual budget submission. Doing so would enhance the transparency of VA's decisionmaking and provide Congress with important information it needs for authorizing and funding decisions. VA agreed and plans to do this moving forward.

Turning to VA's cost estimating process for leases, we found VA's process met several but not all of GAO's standards for reliable cost estimates.

In particular, VA's process was comprehensive and well-documented, but it did not account for common and sometimes large variations between the estimate and actual facility cost. In fact, for 18 of the 23 leases we reviewed, the actual lease costs were at a minimum 15 percent above or below the initially proposed lease cost usually because of changes to proposed design.

For example, actual cost for VA's San Francisco facility were 26 percent over the estimated cost while actual cost for the Montgomery, Alabama, facility were 44 percent below the original estimate. Providing Congress with more accurate estimates would support its authorization in funding decisions.

Accordingly, VA recently issued a new design guide to reduce the risk of changes after proposing leases to Congress as well as a lessons-learned study to identify improvements for its cost estimating process. However, it is still early, and the success of these initiatives or leases currently in the pipeline will depend on how well VA implements them.

Lastly, we found that VA has made progress meeting GSA requirements for delegated leasing authority. For example, as a result of VA's new training and management review process, GSA is now able to approve VA's proposals more quickly. However, few of VA's high-cost leases have gone through GSA's approval process,

and their complexity can make it more difficult to align with GSA's requirements.

In closing, VA should begin implementing our recommendations by collecting the information it needs to assess how it has used the flexibilities afforded by leasing. Doing so will enhance the transparency of VA's decisionmaking process and provide both VA and Congress with data to make the most informed decisions.

VA should also monitor whether its recent changes such as the design guide, lesson learned, and management review process are working as intended so they can make timely adjustments if necessary.

Thank you, Mr. Chairman. This ends my prepared statement, and I look forward to your questions.

Mr. BARLETTA. Thank you for your testimony.

Mr. Sullivan, you may proceed.

Mr. SULLIVAN. Good morning, Mr. Chairman Barletta, Ranking Member Carson, and members of the subcommittee. I am happy to be here today to discuss how VA provides critically needed healthcare services to veterans through a wide variety of leased facilities. The Department maintains approximately 155 million square feet in more than 6,000 owned buildings as well as 33,000 acres of land. In addition to our own facilities, VA has approximately 2,000 leased facilities totaling 25 million square feet.

VA's portfolio is one of the largest in the Federal Government and provides a significant amount of health care to veterans in these leased facilities. In our leased facilities, we provide primary care, mental health, and specialty services, such as ophthalmology, oncology, endocrinology, cardiology, pulmonology, podiatry, neurology, just to name a few.

We also provide pharmacy services, radiology and imaging and same-day outpatient surgery in some of our larger clinics.

Today, I ask for your support to help provide these services to our veterans. VA is requesting the committee's approval of eight pending leases that represent an additional capacity over 1.2 million annual visits to these clinics for our veterans. These eight leases are needed to ensure that VA has the right sized facilities in place to serve veterans with the right services and in the right locations where veterans want them.

Leasing is a critically important tool that allows VA to provide services to veterans. Leasing provides flexibility in lieu of constructing owned assets to meet veterans needs. Leasing enables VA to quickly respond to healthcare advances and to adopt important—more importantly, to changing medical technology in order to provide state-of-the-art health care to veterans. Meeting the ever-changing pace of medical advancement is a constant challenge for any medical system, and VA finds that leasing versus owning provides one of the most flexible approaches to meet that challenge. Leasing also allows us to rapidly adjust to current and future demographic shifts in changing service demands for our veterans.

VA clearly doesn't need more owned legacy assets to address our outpatient access needs. We have enough of old and obsolete facilities, we do not want to add any more to our current portfolio.

For leasing, VA has the ability when these assets become unneeded or obsolete or do not meet current medical practices to

walk away at the end of the lease term. In addition to these 8 leases we are requesting the committee's action on, VA has 24 additional medical leases that are pending congressional action. These critically needed leases will replace, expand, or create new outpatient clinics, research facilities, and provide more than 2.7 million more annual healthcare visits for our veterans and enhance our research capabilities nationwide.

As VA works to meet the challenge of addressing these changing and ongoing demand of health care, these leases, both the eight we mentioned earlier on and the 24, will go a great way to help meet these needs.

As you were aware, VA relies on the authority and has for the last 20 years that is delegated from GSA to enter into all lease agreements. VA depends on its partnership with GSA to obtain individual delegations, to make operating leases feasible to provide services. Our agencies have worked to make improvements, and the delegation process has evolved over the last 2 years.

I want to thank GSA for their partnership and their help in having us move forward with these leases and to provide services to our veterans. They have been more than a willing partner in this effort.

VA is also pleased that GAO in its 2016 report recognized the important need for medical leasing and the flexibility that leasing provides VA. As stated in the report, GAO recognized that leasing allows VA to align its infrastructure more easily with changing healthcare needs. The report highlights some of the improvements VA has made while operating under the GSA lease delegation process and suggests other agencies can implement other processes.

VA fully plans to address the GAO recommendations in terms of further articulating in our budget submissions to Congress via advantages of the flexibility leasing provides, as well as addressing some of the technical recommendations involving cost estimating.

We have agreed to do that and are working with the lessons learned effort to implement and consult with GAO as we implement those recommendations.

As VA works to move the pending leases forward, VA is open to any and all suggestion from the committee or from anyone else of how we can improve your process so we can speed the delivery of healthcare services to our veterans and their families.

I am here with my colleagues to answer any question that you may have or any member of the committee may have. Thank you for your time, and we appreciate the committee's support for our veterans and their needs.

Thank you, Mr. Chairman.

Mr. BARLETTA. Thank you. Thank you for your testimony.

Mr. Wisner, you may proceed.

Mr. WISNER. Yes, sir.

Good morning, Chairman Barletta, Ranking Member Carson, and members of the committee. I am Chris Wisner, the Assistant Commissioner for Leasing at the General Services Administration Public Buildings Service. I appreciate being invited here today to discuss GSA's efforts to provide cost effective and suitable leased space for our partner Federal agencies including the Department of Veterans Affairs.

GSA's mission is to provide the best value in real estate to the Government and to the American people. GSA currently manages an inventory of almost 400 million square feet. Approximately half of this is leased space comprising more than 8,300 active leases across the country. GSA seeks to provide space that assists our partner agencies in achieving their missions while best serving the public interest. GSA's prospectus process starts with requirements development where GSA works with customer agencies to define their space needs. As part of the administration's goal to maximize the use of Federal assets and eliminate unneeded and excess real estate, GSA first looks to the existing Federal inventory of owned and leased space to meet those needs. If existing space is not available, GSA determines whether Federal construction or leasing is the appropriate space delivery method. This determination balances the mission needs of the customer, market parameters, resources constraints, and fiscal responsibility to the public.

If leasing is the chosen alternative, GSA continues to work with partner agencies to further define its program requirements, which includes a comprehensive housing plan, identification of delineated area, and an estimated space utilization rate. The prospectus process also requires market research to establish rental rates. GSA conducts its procurements using prevailing market rates as the benchmark for the evaluation of competitive offers to ensure that GSA rates are in line with the private sector.

After we complete this thorough process, GSA submits a prospectus and supporting documents for projects that exceed \$2.85 million.

In 2014, the VA began relying exclusively on GSA's delegated authority to conduct its leasing activities. Some of the VA's request for delegated leasing authority are above the GSA's prospectus threshold. GSA will submit prospectuses to this committee and to the Senate Environment and Public Works Committee.

The initial delegation request from VA required a number of revisions to comply with GSA's delegation program requirements both in form and substance. As delegation requests above GSA's prospectus threshold were not within the normal delegation program management, there was no standing GSA process for considering such an authorization. GSA and the VA have worked together to ensure VA's documents are in line with similar GSA prospectus submissions.

GSA supports VA's mission to provide assistance to veterans and their families. From June of 2014 to September of 2016, GSA has granted the VA 761 leased delegations, of which 96 percent have been granted routinely under GSA's standing delegation program. Only 4 percent, or 27 of those delegated leases, have exceeded the square foot limitation that requires action by the GSA Administrator. Only 6 of those 27 exceed the \$2.87 million prospectus threshold.

The Choice Act was enacted in 2014 to provide new authorities and funding to continue VA's mission, including statutorily authorizing the Secretary of Veterans Affairs to lease medical facilities in 18 States and Puerto Rico. Out of these 27, there are 8 remaining that are above GSA prospectus threshold. The committee's help is

needed in providing GSA with resolutions for those projects, and we plan to submit this package in the upcoming weeks.

As we move forward in our partnership, VA and GSA are working closely to ensure VA projects comply with GSA's policies and practices. With VA's expertise, discipline and structure can be applied to market rate justification for VA prospectuses. Furthermore, as part of strategic planning, VA and GSA can identify opportunities for VA to backfill existing underutilized and vacant space instead of initiating new leased actions.

Chairman Barletta, Ranking Member Carson, and members of the subcommittee, GSA is dedicated to meeting the requirements of all of our partner agencies in an efficient, transparent, and user-friendly manner. We will continue to support the VA in their mission of providing assistance to veterans and their families.

Thank you for the opportunity to testify before you today, and I am happy to answer any questions.

Mr. BARLETTA. Thank you for your testimony.

I will now begin the first round of questions limited to 5 minutes for each Member.

If there are any additional questions following the first round, we will have additional rounds of questions as needed.

Mr. SULLIVAN, in September of 2014, this committee approved six VA leases, which were above GSA's prospectus threshold. What is the status of each of those leased projects, and have they all been awarded, and when will they be completed and open?

Mr. SULLIVAN. Sure. There were six leases that the committee approved back in 2014. Five of the six have been awarded. The last one is Rochester, New York, which should be awarded in the first quarter of 2017, based upon my information from the contracting officials.

The first one Springfield, Missouri, was awarded in February 28, 2016, and we expect to have it open in the spring of 2018. Butler, Pennsylvania, was awarded in December 2014. We expect to accept the building in the summer of 2017. San Jose, California, was awarded in September 2015, and we expect acceptance in the winter of 2017. South Bend, Indiana, this lease was awarded back in July 2015, and we expect to accept the building again in the summer of 2017. Mobile, Alabama, was awarded on August 18th, 2016.

I will be happy to provide the committee with all the specific dates and milestones for each of these leases.

Mr. BARLETTA. Thank you.

Mr. Sullivan and Mr. Wisner, what steps has VA taken since 2014 to work with GSA to prepare the additional eight leases that are above GSA's prospectus threshold for approval by this committee? Where are those leases in the process? And when can we expect them to be efficiently submitted? And why have they taken so long?

Mr. WISNER. I will take the first part of that.

So, sir, we have the full packages from the VA in hand currently. They were received in final form July the 26th, I believe. We are in the process of processing those and testing them for operating leased—the operating leased threshold. I expect we will have them through our stakeholders and with signature for submission to this committee in coming weeks. I would say in 7 to 10 days.

Mr. SULLIVAN. Yes, Mr. Chairman. We have worked with GSA since that time to establish several efforts to improve the product they received from us and the timeliness of the product that we provide them. We have set up a central clearing house that reviews all the leases that go over to GSA. We set up a peer review to make sure that the products are of top-notch quality that go over to GSA. And I think that's been demonstrated in the quick turnaround time that we have an average of 20- to 25-day turnaround time for leases that don't require external approval.

We have also set up tracking systems so in VA we know where every single lease is, both our leases that are in the procurement chain that GSA sees but also all of our existing leases. So for the first time, we have a complete inventory of all leases in process that are executed, all leases that are operating, and all leases that are in the procurement process, as well as all leases pending congressional action.

We have also set up an integrated budget tool for the first time in 2017, and it will be reflected in our 2018 estimates to Congress where we allocate the funds and track the funds based upon the schedules of our 1,200 leases of when we will need the money, and what year we will need the money, and whether we need capital money or we need the FTE associated with it.

So we have a really, I think, a good handle on what our requirements are and what—importantly, what is the liability of those requirements as we go out in time. Because as we have seen, as many of the members that are on the Veterans' Affairs Committee have seen, an influx of significant workload. We have put our leases in place and have predicted what the liability of those leases will be in 2017, 2018, 2019, 2020. We do it out 5 years now, so that is a big improvement that we started to address the leasing.

We have also set up internal training sessions. As you imagine, VA is a very complex organization, spread across the country. And many of our small leasing below \$1 million is done in the fields, so it is important for us to train and provide expertise, and GSA has helped us do that to those people who are actually executing the leases.

So I think we have taken a lot of steps. It is not perfect by any means. And as we go through the various budget estimates that come out each year, we get a little bit better a little refiner and we integrate our data and provide a better estimate to Congress of our liabilities.

Mr. BARLETTA. Why do you think they have taken so long?

Mr. SULLIVAN. On the eight that are coming up to the committee now? Two reasons, really. When we submitted the last batch, we took the ones based upon the priority of where they were in development, how complicated they were. And the ones that we knew were closest to award, we submitted to the committee in the first six.

The last eight are probably the more complex, larger leases where we had to do the market research, the planning for the space requirements and the design requirements for those leases, so those took a little bit more time. So it was more of a priority of what we could get through and what we were ready to present.

We did not want to present the committee with an incomplete package.

Mr. BARLETTA. How much of the delay is due to structuring the leases to score as operating leases as opposed to capital leases?

Mr. WISNER. So I don't believe that there is any delay in the structure between a capital and operating lease. There is full commitment from GSA and from VA that we will not bring forward anything that has the potential to become a capital lease. That was part of the controls that were put in place in 2014. I don't think that there is an adjustment that is made at all. When there is the risk of a capital lease, we stop that prior to any award. So there are several checkpoints along the way, and ultimately, if we started to go down the path or VA started to go down the path of coming close to a capital lease, I think we will probably pause and take a look at that. But right now I don't see any delay when we are—we have enough discipline in our program that we do not move even close to anything above an operating lease into the world of capital.

Mr. BARLETTA. Thank you.

The Chair recognizes Ranking Member Carson.

Mr. CARSON. Thank you, Chairman Barletta.

Ms. Shea, in your testimony, you indicated that the VA has not provided Congress with information that backs up their conclusion that its choice to have lease—to lease these facilities, which is more expensive than construction is justified. What metrics do you think would be helpful for the VA to consider, ma'am, convincingly to make their case to Congress that leasing provides the flexibility that they repeatedly claim?

Ms. SHEA. Well, what we looked at in our report was the process that VA goes through to decide if it should lease. We looked at 51 leases that were proposed to see whether leasing was the right approach. And in all 51 of those leases that we reviewed, they indicated that they required the flexibilities that come with leasing. And sometimes this could even be when the choice to lease was more than the choice to own or construct. This goes back to one of the reasons we made the recommendation that VA does need to provide information on how it has used these flexibilities.

For example, with the requirement that leasing has for the VA to vacate after 20 years, are they—when they need to find a new leased space—still leasing in the same area: are they really having to move because the patient demographic has changed; or are the seismic security and other standards really not that different from when the lease ended?

So there are a lot of things that, on its face, seem like the flexibility is useful for VA, but they aren't collecting any of the information to demonstrate how it has used that flexibility. Did they move? Did the patient demographic change? Did the seismic and Federal security standards change? Did they record that? Did they then show how they benefited from that flexibility, and that they need that moving forward?

And so we made that recommendation to VA, and they have agreed to do that and include that information in its prospectuses going forward.

Mr. CARSON. Yes, ma'am. Thank you.

Mr. Sullivan, what are the cost controls as the VA puts together a program of requirements for a leased facility? Do costs ever cause the VA to not lease or build a clinic because it is simply too expensive?

Mr. SULLIVAN. VA develops a rigorous business case for each of its leased actions. And in that, the business cases flow up from the clinicians in the field who actually are delivering care to the veterans. And we look at them to, first, look at whether they need a capital asset in the first place. They look at other alternatives before they look at leasing to see if that is more cost effective or more appropriate to do, and then they look at build, and then they look at lease.

In terms of the cost analysis, we look at what the industry standards are. We look at what indices are showing of what leases should cost adjusting them for some of the Federal standards to ensure that we are submitting reasonable costs to the Congress when we submit these proposals. And then when our contracting folks execute it, they have to ensure that the cost, the rental rates, we are paying for these leases are reasonable.

One thing I would say on cost, Mr. Carson—

Mr. CARSON. Sure.

Mr. SULLIVAN [continuing]. Is when you look at the real estate costs of providing care to veterans, we did a little analysis a few weeks ago. And looked at what we see in the lifecycle of a lease. When you look at a lease when you are providing care for veterans, the real estate costs of a lease are less than 9 or 10 percent of what the cost it is to provide care for veterans. When you really look at it, the real cost of deciding to put a clinic in, it is the docs; it is the nurses, it is the schedulers, it is all of those people that are there, and the real estate costs are really the small amount.

So when we look at the consideration, we have always put with the question by people, you know, you could have a real estate solution that is 25 miles down the road that is \$3 cheaper a square foot. But if the veterans, where they are, where they live are 25 miles away, our alternative has always been to put the clinic where the veterans are, closer to them, even if there is a cost difference. We look at in the life of the lease, it is more important to provide the right services where the veterans are rather than to get, say, a primo real estate deal 45 miles away. And we have had where people have come in and said, hey, we could save you \$10 a square foot if you move 60 miles down the road. I guess you could, but the people wouldn't have access to it.

The same thing in metropolitan areas. People are saying, well, if you can move one, you know, the other side of New York City, I could get you \$3 off. Well, if the veterans are in Manhattan, you are going to put it all the way out in Queens, people in the area, that is a 2-hour commute difference. That is a huge impact on veterans. We look at the costs that way as well. Thank you.

Mr. CARSON. Now that we are out of time, thank you for the very deep explanation.

Sorry, Mr. Wisner, I won't get to you. But nice haircut. My kind of guy.

Mr. WISNER. I try.

Mr. CARSON. I yield back, Mr. Chairman.

Mr. BARLETTA. The Chair recognizes Mr. Meadows for 5 minutes.

Mr. MEADOWS. Thank you, Mr. Chairman. Thank you for your leadership.

Thank you each of you for being here.

So, Mr. Sullivan, let me come to you, because I guess I am a little confused when Ms. Shea says that the flexibility is a big issue for you signing up for leases. And yet, you have not, to date, provided that kind of information.

Mr. SULLIVAN. I think we are talking a little bit of different levels of information. In the prospectuses that we send to Congress, we articulate why we wanted to use leasing, and we articulate the flexibility that—

Mr. MEADOWS. And why do you want to use leasing? Because most of the build to suit, I understand as a private sector guy, why you want to do that, you write off the expenses and so forth. But from a public sector standpoint, if you are doing build to suit, how in the world is that generally—because normally, a lessor is going to write off the cost over a 20-year lease of the entire cost in case you don't re-up, how is that a benefit?

Mr. SULLIVAN. To us, it is a big benefit. When we look at what we—when we provide outpatient services in a leased facility over—most of our leases are 15 to 20 years. If you look at the changes in medical technology, 20 years ago where you are, you know, standard practice now is, for example, to have a CAT scan, to have an MRI scan, to have some oncology services—

Mr. MEADOWS. No. I get all that. I guess what I am saying is if the cost of the lease covers the entire cost of construction that you are paying for, and yet, you don't have an asset at the end—it is kind of like a car lease. If you are paying the entire—if the residual value is zero at the end of the car lease and you don't own it, what is the benefit from a public sector standpoint?

Mr. SULLIVAN. From a public sector standpoint is that we don't have an obsolete, outdated facility at the end of 20 years that we have to go back in and retrofit if we owned it. And we have, unfortunately, many of those facilities in VA, and we don't want to add more to that stock.

Mr. MEADOWS. Apparently, we are missing at each other.

If you are covering 100 percent of your cost in the lease, 100 percent—

Mr. SULLIVAN. Correct.

Mr. MEADOWS [continuing]. All right? Even if it is outdated, it becomes an asset that GSA has, and you can start over again.

I was in the real estate business. I know it extremely well. So I guess what I am saying is are you leasing at less than the full cost of the build to suit? I mean, is there a residual value there?

Mr. SULLIVAN. There is—depending upon the transaction, there can be a residual value. But at this point, if we were to build instead of lease and we—from the beginning, we would need to have all of that money upfront. So right now, in a big lease, say of 200,000 square feet, we are paying, say, \$3 million a year in rent, or \$4 million, depending on the market, where it is. We would need to have \$35 million—

Mr. MEADOWS. You are saying because we are not allocating it upfront, you are actually using a lessor to do it over a 20-year period?

Mr. SULLIVAN. In your example, yes.

Mr. MEADOWS. OK. All right. So what analysis have you had from veterans in terms of location? What matrix do you use?

Mr. SULLIVAN. We have a detailed healthcare planning model that goes all the way down to the zip code.

Mr. MEADOWS. Who gives you input for that?

Mr. SULLIVAN. It comes from external contractors that take census data, utilization data.

Mr. MEADOWS. How many veterans do you talk to when you do that?

Mr. SULLIVAN. I don't actually do that. We get that from an office of healthcare—

Mr. MEADOWS. How many veterans do they talk to? Because here is what happens is, is a lot of times we make decisions on locations, and it is based on a perception. But sometimes we don't actually get the input from those who are going to use the facility. Do you not see a problem with that?

Mr. SULLIVAN. I believe there are two things I was saying. We get overall projections of what the need is in the catchment area for a clinic; i.e., based upon census data, veteran pop in the future, and expected utilization. We then go down to the clinicians at the local level. Those clinicians at the local establish what is known as the delineated service area for that procurement. They determine, based upon their knowledge of the local market, the local preferences of veterans, and local clinical availability of resources where the type, delineated service area would be for where they believe those veterans will come for services. That is going to be different based upon each and every market. So they reach down. And they are the ones who establish the delineated service areas.

Now, our folks here in Washington cannot, you know, come up with a delineated service area, because they know what the local market is and what the local—

Mr. MEADOWS. I agree. And so what you are saying, it is going to be made at the local level not in Washington, DC?

Mr. SULLIVAN. Yes. Correct.

Mr. MEADOWS. So let me finish in the 23 seconds we have left.

Let me ask you. As we start to look at these allocations, how many times out of the 700 and some odd times that Mr. Wisner had mentioned that has been delegated to you, how many times have you actually left a location and gone to a new location because of the flexibility that Ms. Shea talked about?

Mr. SULLIVAN. I would have to get for you, but I would say numerous places that we have move—

Mr. MEADOWS. Could you get the number to the subcommittee on that?

Mr. SULLIVAN. Sure. It would take a little bit of data, but we could get that to you.

[The requested information can be found in Mr. Sullivan's response to Mr. Meadows's question number 4 on page 49.]

Mr. MEADOWS. Thank you. I yield back.

Mr. BARLETTA. And that is why we have to reform our disposal rules, and we have that in our bill. And the second thing is we also in our bill have a discounted purchase option which would allow you to buy, so I think they are very good points by Mr. Meadows.

The Chair now recognizes Ms. Brownley for 5 minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman. I appreciate it. Thank you. And thank you, Ranking Member Carson, for allowing me to participate in this morning's hearing.

As the ranking member of the House Committee on Veterans' Affairs Subcommittee on Health, I have been working for several years now to address problems in the VA's construction and leasing program. As we all know, changes in CBO's scoring have made it incredibly difficult for the VA Committee to authorize new facilities. This is not only frustrating to me as a Member of Congress, but it is having a very negative impact on veterans who are underserved.

This is not just about better access, but it is truly a clarion call for equitable access for all of our veterans. I have brought a list today that I would love to share with the committee of 24 leases still caught in limbo for fiscal year 2015 and fiscal year 2017. These are 24 communities in 15 different States all across the country where veterans are underserved and where veterans sorely need better access to health care and are not receiving it. I am frustrated that Congress has not yet resolved this issue that has dragged on for several years now, an issue I think is a moral imperative and unquestionably an equity issue.

I have introduced legislation to permanently fix this problem and to harmonize the VA leasing process with the GSA leasing process. This small procedure will make a big difference in the lives of veterans who are waiting for and rightfully deserve better access to care.

That brings me to my first question. Last year, the VA Committee held a hearing on my bill, the Build a Better VA Act. At the time, VA was not prepared to answer specific questions regarding the administration's position on the bill. My bill has been endorsed by several VSO's and the Commission on Care has identified this as an area that needs to be addressed by the VA.

So, Mr. Sullivan, has the VA now had time to review my bill, and does the VA support this approach? And if you don't, what is the VA's proposed long-term solution to addressing this ongoing problem that we have with authorizing the facilities?

Mr. SULLIVAN. The VA does support your bill, and we support your efforts to look at the streamlining of the authorization process that is outlined in your bill.

Ms. BROWNLEY. Terrific. That is very good news. Thank you for that.

Ms. Shea, I appreciate the work that GAO has done to ensure that the American taxpayers are getting a good value for their dollar. I share the views of my colleagues that cost effectiveness is an important tool for measuring value. However, I also believe that when it comes to veterans' health care timely access—timely access to high-quality care should be our absolute highest priority.

So, Ms. Shea, did the GAO analyze the length of time that it would take to build new VA healthcare facilities from the ground

up versus the amount of time it would take to build out a leased facility?

Ms. SHEA. We didn't look at the time to build or lease in this report, but we did look at the time to deliver a facility through leasing in the 2014 report. And we found that there are still delays in that process, but most of those delays were in the upfront side before they were delivered, and the delays were on average 3.3 years. And we don't have comparisons to VA construction, but based on some of the other construction work that we have done, there are generally longer delays for construction.

Ms. BROWNLEY. Thank you.

You know, I certainly think timeliness is—you know, is critically important in terms of—with the goal, the sole goal of quality health care and access to that health care for our veterans. So, you know, I understand some of the issues that have been discussed here, but I also believe that getting a leased facility to our veterans as quickly as we possibly can, assuming that it is cost effective, is critically, critically important.

And finally, Mr. Sullivan, from the perspective of the VA, can you just describe, again—I know you have already said some of this already, but what advantages does leasing have over construction? You have talked about flexibility and timeliness. And do you believe, still, that the option allows the delivery of health care to happen more swiftly?

Mr. SULLIVAN. Yes. We believe leasing we can deliver there quicker. We can put an asset in place quicker—sorry.

We believe that leasing provides a more expeditious way to provide healthcare services to veterans. We believe leasing is the right thing to do in terms of allowing us to change the types of services we need if we—at the end of the lease or if we have a shorter term lease. We believe technology is the big driver in health care. And for us to be able to have a 20-year old facility that took 2 years to plan, so 22 years out, that that technology is going to change, especially in the area of radiology, imaging, oncology, and those areas. It is night and day what it was 20 years ago, and we need to be able to have those facilities that have that up-to-date technology.

There are challenges with the leasing process, I don't doubt that at all. But we believe that flexibility and also the flexibility if we have a new cadre of veterans that come in that demand new services that we don't know about today, leasing will allow us to shift, to provide those services where they are. And especially as we deal with some of the younger veterans coming into—from the Persian Gulf wars and more recently that their need for services are different and they want them in a different time in a different place than people who are from the World War II Vietnam era. So we need to balance that as we go forward, and we think leasing provides us flexibility.

There is a need for owned assets. I am not saying there isn't. But in the outpatient arena where access is key, we believe that that is important.

Ms. BROWNLEY. Thank you, Mr. Chairman, for allowing me to be here and allowing me to go over my time. I yield back.

Mr. BARLETTA. Thank you for coming.

The Chair now recognizes Mr. Costello for 5 minutes.

Mr. COSTELLO. Thank you, Mr. Chairman.

Before I got here, I used to be a real estate lawyer, and I used to negotiate leases. And it was not necessarily a fun endeavor, but I did learn that it is very value added. And I do think that the questions today are largely oriented towards improving the efficacy of the leasing process, and that is what we want to see. We just don't want to see us paying more money than we should pay in a lease. And I think we also want a cleaner analysis on, to Mr. Meadows's point, the valuation between an outright purchase and—or build to suit versus a 20-year lease.

And in looking, Ms. Shea, at your analysis here, it strikes me that the issue that the VA is deficient in, relative to this analysis, comes under the credible characteristic and, most specifically, the conduct risk and uncertainty analysis.

And I find that to be consistent with the conclusion without analysis criticism that we say, oh, it provides more flexibility and so, therefore, we should do it. I happen to think that it, in a lot of instances, leasing a medical facility probably is the more prudent cost, because unlike a lot of other real estate assets and office building, certainly raw ground, with a medical facility, there is a functional obsolescence after 20 years. And that you do run into negative equity much quicker. I mean, in my home township, we have an old mental health facility that, you know, 20 years later it was still there, and it was negative \$8 million on an appraisal.

So for Mr. Sullivan, what I would like to hear from you is what do you intend to do to address the shoring up the risk and uncertainty analysis, which I think will go a long way toward addressing Ms. Shea's report where the VA is deficient? The other question that I would have for you, Mr. Sullivan, is contained on page 10 of Ms. Shea's report which references the fact that the VA plans to conduct a, quote, "lessons-learned study that could further improve how VA estimates its costs."

And the final point I would make, and then I will turn it over to all of you, is those of us who serve on the VA Committee, and I think even beyond that, the delivery model for caring for veterans is changing very rapidly, telehealth. We have a facility in my district where a lot more is done that way. And we look at the way e-health is able to provide services. It just doesn't require as much physical space. And some of it is space that once built can remain flex space.

So I would ask for your take on that. And I think that that is part of the risk that I mentioned.

And in the final question I have for you, Mr. Sullivan—I am sort of doing it all at once is, the report that McKinsey issued in 2015 found that for larger built-to-suit medical facilities, VA rents were 40 to 50 percent higher than private sector benchmarks. I think that that brings back into the fold of Mr. Meadows's point on, well, why don't we just do a build—I mean, why not build to suit and own it if you are going to be paying 40 to 50 percent higher? It is one thing if at the end of 15 or 20 years, it's like, OK. We paid for it, and now we are at zero and we have a facility, and maybe it is worth something, maybe it is not. It is a whole other thing when you are paying 40 to 50 percent over and above.

Then the final point, I am not so keen on—I mean, we have enough examples on the VA Committee where VA construction projects end up a whole heck a lot higher than they should, which I think, points again, to leasing versus building. If it is a 50–50 proposition, I think I would probably lean towards the leasing.

I have said a lot. I turn it over to you for your comments on my comments.

Mr. SULLIVAN. Sure. I will try and take them as I jotted them down here. In terms of the cost lessons learned that GAO recommended, what I believe that lessons learned is going to do is, right now we treat each procurement, it goes through a process. We do a fair and reasonable assessment before we award. What we have from that result is we have individual instances of costs. And I think what GAO is saying from a portfolio perspective to take all of those costs as you get them, roll them back into your estimating model.

Right now, it may or may not be done. It is not required, so we have agreed comprehensively to do that. That data is there. It is just a matter of us going forward and pulling it forward.

The same thing on the risk in terms of whether we really move out of these facilities or we really will use them. The data is there in the decentralized environment. And we defer to the locals. When we submit the budget, we can easily pull that data, and we will do it for the committee that shows where we have moved, whether we have upgraded the facility, or whether we have stayed in place.

So I think the data is there for that, and that will really inform, you know, how much risk are we really avoiding by doing this.

I think everyone just intuitively and all the clinicians intuitively live in these facilities day to day, and they know there is no way that they should stay in that facility, not only due to the changes in care, but the security, the setbacks, and all of those things. We take them from their gut, but we need to get the data to make it clear to everybody that that is and that is fair, and we will do that as soon as we can. We have it, just a matter of aligning it.

In terms of the McKinsey report, we will have to get you more specifics on that. I believe some of the comparison made in the McKinsey report was made to private sector healthcare facilities that do not have some of the Federal requirements that we have to handle. But we can get that for you. We are familiar with it. It is a pretty thorough report, and we are happy to provide you and the committee with that.

Mr. COSTELLO. And that would be providing veterans care.

Mr. SULLIVAN. Right.

Mr. COSTELLO. There could be some good explanations. I am just looking for that.

Mr. SULLIVAN. Right. Because there is a big difference. Our clinics and one of the things we talk about a lot is when you compare an MBO medical office building to a VA clinic, they are very different. And a lot of the benchmarking people use against us are medical offices buildings and—

Mr. COSTELLO. I understand.

Mr. SULLIVAN [continuing]. Apple to orange. But we are happy to provide that to you. Thank you.

Mr. COSTELLO. Thank you.

Mr. BARLETTA. The Chair now recognizes Mr. Rouzer for 5 minutes.

Mr. ROUZER. Thank you very much, Mr. Chairman.

And I want to follow up on my colleague, Representative Costello's questions and your answer there.

I have a specific case, in Wilmington, North Carolina, where we have our Wilmington VA clinic, basically, a brand new building. There is a lot of concern among constituents and my veterans in particular, about the—what they feel is an outrageous figure that we are paying for that space, roughly to the tune of \$300,000 a month.

Now, I heard your answer there at the very end to Representative Costello where you are saying—when you compare the prime medical space elsewhere, it is not necessarily apples to apples, perhaps apples to oranges. But when you consider the fact that it is \$300,000 a month, and the vast majority of my constituents, they are probably thinking in terms of a 30-year mortgage, and that is far and above the average 30-year mortgage in my district. So there are a lot of questions about, you know, how do we negotiate these leases, and are we just absolutely being raked over the coals with this?

So if you can elaborate more on how you go through what that process actually is.

And I am curious where GSA fits into this. Who actually negotiates the lease? Is it GSA and with—in consultation with the VA, or is it the VA with advice from GSA? If you can explain how that works, I would be interested.

Mr. WISNER. So I will take the first question—or the last question first.

Mr. ROUZER. Sure.

Mr. WISNER. GSA provides advice to VA. VA has their own lease contracting officers who are trained to use the GSA program, GSA forms, and the Government leasing process. So they follow the FAR, they follow the GSEM; they follow all the rules and regulations there are related to GSA. Part of this relationship is if you use GSA's delegated leasing authority, you follow GSA's policies and practices.

I must say that the program has improved significantly with VA in the past 2 years. The centralization that Jim has been speaking about on bringing the decisionmaking to a central point and having prioritization and decisions made through that has been extremely helpful, and I think there is more that you will see in the near future.

So VA does their own negotiations. We oversee through a delegation of authority, and then we do pre-award checks to make sure they are not capital leases. We also do post-award checks to ensure that they followed all the rules and regulations, and then we do clean up actions afterwards if necessary.

Mr. SULLIVAN. I can tell you have we have an entire organization that, as Mr. Wisner referenced, is our contracting elements that actually contract and do all of the solicitation, the evaluation, and the selection of the winning proposers on these. I know generally that they validate with benchmarks and appraisals the rates that they pay. I am not that familiar with that case. I would be happy to get

you the information or whatever way you want. I would be happy to sit down with you and go through that so you can understand what the process was in that particular case.

Mr. ROUZER. Well, I would very much like to get that presented to the committee because that is a big question mark in the minds of many of my constituents when they look at that figure.

One thing, if you can expound on this a little bit, you mentioned that you use prevailing market rates as you try to negotiate these leases, but yet if you have a medical clinic and you have no comparable, per se, facility to measure against, how do those two mesh? I am not sure I follow that.

Mr. WISNER. So this is one of the most challenging things that we have had to work with and are trying to understand more of. GSA typically acquires general office space. The VA works through a market analysis and then does a type of buildup to get to a cost of what their hospital should be. There are lots of questions back and forth between our program. We are trying to understand more about how the VA establishes those costs, and I know the VA internally is working on cost estimating and improving the mechanism by which they do these cost estimates.

We have access to many databases, RF means, et cetera, where we can look and validate on what the VA has. I think that there is still room for improvement on this market rate question, but what we have before us today is by far an improvement over where we were 2 years ago.

Mr. ROUZER. My time is expired. Thank you, Mr. Chair.

Mr. BARLETTA. Thank you. The Chair now recognizes Mr. Massie, for 5 minutes.

Mr. MASSIE. Thank you, Mr. Chairman. Last week Chairman Mica had a good hearing about property and assets and how difficult it is for us to dispose of them or turn them over back to the private sector, so I can definitely see the benefits of leasing, but I left that hearing with a question and I still have that question in this hearing—it seems to be coming up—which is how good is our database of properties, leased and owned? Because some of the questions we are asking today we could answer ourselves if we could get on a computer and just query the database. We wouldn't even have to show up to get some of these apples and oranges questions answered. We could go into that database.

Mr. Sullivan, let me ask you first. How close are we to having a full database of all the properties that, for instance, congressional staff could look at?

Mr. SULLIVAN. I think there are two levels of data, as I understand it. There is the Federal real property database that is run by an outlet, and it is a little bit out of Mr. Wisner's area, but GSA runs, which includes all Federal assets across all agencies. I believe most of what is in there is civilian-based data for civilian agencies, and I believe that information has been and can be released to committees and other people with interest. I am sure that we could find out what the status with that is.

In addition to that, we have kind of a subsidiary database, if you will, that has a little bit more granularity so we know where all of our assets are, all of our leases are, so between the two of those, I am sure we could provide any information that you would want.

Mr. MASSIE. My next question on this topic is to Ms. Shea and Mr. Wisner. You deal with property across various Departments, not just the VA, is that correct, that is in your jobs?

Mr. WISNER. Yes, across the Federal Government.

Mr. MASSIE. So my question to both of you then—so I assume you do as well, based on your title, Ms. Shea—how does the VA database compare, because I am sure the DOD has maybe a different type of database, and I am sure there are certain Departments that maybe keep more information about let's say the constraints on the property if it ever were to be released to the public or something like that.

But how does the data on the buildings that we have within the VA, leased and owned, compare to the data in other Departments? Are they doing a better job or worse job?

Mr. WISNER. Yeah. So I have not looked at the database that the VA has internally. I mainly work with the FRPP, which is the Federal Real Property Profile database. I believe that the majority of the property that VA controls is fed into the FRPP, so it would be difficult for me to comment on something that I haven't seen yet on the VA database.

Mr. MASSIE. Ms. Shea.

Ms. SHEA. Right. And that is a bit outside of the scope of this review, but we have in our other work for real property used the FRPP and looked at that extensively. And perhaps at the hearing that you are referring to, my colleague Mr. Wise mentioned that there are fewer than half of the Federal properties that are in that database because if you have independent leasing authority, you won't be in that database. So VA is in that database, but we didn't look to see how its own internal database for properties compares to the FRPP.

Mr. MASSIE. It just strikes me that if the data was out there, you would almost sort of have crowd sourcing monitoring and reporting of this that it would just happen, and you would have realtors combing through that database, looking for, OK, in 3 years, this property is coming up and the Government is going to want to dispose of it. I think it would be handy to have the lease information in that database, particularly if the bill we are talking about here is going to allow sort of a purchase agreement at the end. That way we do want to compare apples to oranges when we look at should we buy that property at the end of the lease. So we want to have a comparable database for the lease stuff, wouldn't you think, Ms. Shea?

Ms. SHEA. I think GAO is always in favor of having centralized data that we can look at, so yes.

Mr. MASSIE. All right. I am in favor of that, too, and I yield back my remaining 30 seconds.

Mr. BARLETTA. Thank you. I am going to start a second round. I just have one or two more questions.

Ms. Shea, the GAO noted that the VA has made progress in meeting GSA's requirements. Can you highlight key challenges that there may be?

Ms. SHEA. When VA first started going to GSA for delegated leasing authority, they had a bit of a learning curve. And since that time, they have done three key things, including, as Mr. Sullivan

mentioned, a management review process so that every single one of the proposals—before it gets put into the database—gets reviewed to make sure they have got all the right documentation. They also ensure that all of their contracting officers received this training that they needed to understand GSA's requirements and to make sure that they had all the documentation at the ready.

And lastly, according to both GSA and VA, there is a lot greater coordination among the two, and there are, for example, weekly meetings to discuss the issues. I guess the issue for us is that they have implemented this process, and that is all a very good thing. But that is mostly for the lower, the non-prospectus-level leases. They have applied that to those. It may be harder to make sure that the prospectus level leases are in alignment with GSA's requirements. And so it is something that they are just going to have to test and see how well it works and continue to monitor those new practices and make sure that they are working for the larger leases as they move forward.

Mr. BARLETTA. Mr. Sullivan, in your analysis as to whether to lease or own a medical facility, how does the VA take into consideration existing space that may be available?

Mr. SULLIVAN. When we do a procurement for a replacement lease or an expansion, and many of our leases not only replace what is there, but they expand it, we look first to see if there is an existing asset somewhere that we can do. We also check with GSA. As Mr. Wisner said, we are just as happy if we can find a Federal building that has space that is located where veterans are, to us it doesn't—unless there is some special need in that clinic that can't fit within a Federal building—or a lease that GSA has that has come free because another tenant doesn't want it, if there is someone who can use it, we are more than happy to take that.

So we look at existing first because it is going to be usually in a lot of cases if the bare requirements for our lease don't have a lot of specialties in it, we could move in a lot quicker, which means that we can provide services quicker, and that is what we want to do. So we use that as our first look in the procurement process and in the process of delegation to GSA. When we don't find ones there, we do go out, and they end up going through the procurement process.

Mr. WISNER. Sir, we have several examples where this methodology has worked. We have had a number of vacant spaces where we have aligned with the VA. They have been able to move into the space in a more quick fashion. These are the smaller C-box, and I call them retail spaces so obviously not large prospectus-level leases that you would see, but in the operations we have seen quite a few number of leases where we have been able to backfill.

Mr. SULLIVAN. It should be noted all of our nonmedical leasing, I mean, we do not portray to have significant expertise in nonmedical leases. So all of our nonmedical leases, whether they are for cemeteries, veteran benefits, or overhead leases, are all done by GSA, as they should be.

Mr. BARLETTA. Thank you. I have no further questions. Ranking Member Carson.

Mr. CARSON. Mr. Wisner, in January of 2016, the VA issued a new standard design that covers the different types of facilities

that the VA procures. The GAO indicated that design changes are the main drivers of increases of costs for a facility. The committee previously tackled the issue of courthouses spiraling out of control with increases related to deviations from the design guide for courthouses. What are appropriate reasons for the VA to deviate from the design guide that they have completed, and would you recommend that our committee resolutions require congressional notification if the VA departs from the design guide at all?

Mr. WISNER. This is probably a two-person question, but I will start off. As I understand it, the VA has established some standard types of hospital and delivery mechanisms which can be categorized, and I just call them like the big three, the types of hospitals or types of locations that they need to acquire. That will help a lot in the world of standardization. I don't know necessarily if we need to go to the level of notification to Congress if they deviate. You might look at it from a standpoint of risk. How much have you deviated, and how much of a notification do we require around that? But I think the standardization is going to go a long way.

Many of our customer agencies—I am working with the United States Coast Guard right now—are moving toward standard platforms of what we will acquire other than individual one-offs across the portfolio. So standardization is, I think, something that we should push more, and we should look for that discipline across the entire portfolio.

Mr. SULLIVAN. I agree with Mr. Wisner. We are doing three types of standardization. At the lowest level we are doing something called patient-aligned care teams where we set up modules where we predesign what services will be provided and create standardized areas where outpatient services are provided, and we set them up in teams. So you can get one module, two modules, six modules. You build on it.

The second thing we are doing is we are doing a prototype what we are calling, what Mr. Wisner referred to, we have a small, medium, and large prototype for outpatient clinics trying to standardize that process. And then the third effort, which is less mature than those two, is we are looking at all of our contract documents and all of our contract standards that we have out there for building and designing and trying to reduce and make them, to the extent we can, more aligned with what private sector practices are in the healthcare practice, which is an ongoing effort, and we do have a lot to go on that effort, but we believe that is what we need to do to bring us more in align and lower cost. And we are pushing forward to do that, probably on new leases in the coming years, to look at standardizing that more to make it easier for the private sector to come in. Thank you.

Mr. CARSON. Thank you. I yield back, Mr. Chairman.

Mr. BARLETTA. Thank you. The Chair recognizes Mr. Rouzer.

Mr. ROUZER. Thank you very much. You may have answered this when I had to step out, but I am just curious. What is the percentage of those facilities that are leased versus owned at the VA, security slip that is overall?

Mr. SULLIVAN. We have about 25 million square feet leased and about 158 million owned, and the lease has significantly increased while the owned has held steady, or we are trying to move it down.

Mr. ROUZER. Got you. At what point in time did you change your focus to leasing versus owning?

Mr. SULLIVAN. I don't know if we completely changed our focus, but if we look back about 5 years ago, we had a major change in the way we provided health care, maybe a little bit longer, but we shifted more to the outpatient area. That is when the leases, say, 10 years ago started to take off because we wanted to move it to the outpatient setting, closer to where veterans are, not in the hospital. So we kind of have focusing on us a perfect storm that VA is coming through.

We have a whole series of leases that started 10 or 15 years ago that are all becoming mature, and we need to move out. At the same time, as everyone in our world knows, we have been hit with an unprecedented workload increase, which require new clinics because we don't have the capacity. So you have the expiring old ones and the new ones and then updating all of the new ones for technology and security and safety, so we kind of have this large cloud that is coming at us, and that is what we are trying to work through.

Mr. ROUZER. Got you. Going back in my memory bank, and this goes back to when this issue at VA clinic in Wilmington came to light, and we were paying roughly \$300,000 a month. I remember being told by somebody somewhere—the specifics I don't recall precisely—but basically that they did not look at prevailing market rate. They looked at other comparable VA facilities or other Government-owned facilities elsewhere in the country. And so initially when I was listening to you, I was trying to reconcile that with the comment about you do look at market rate.

And then, of course, in response to Representative Costello's question, market rate really doesn't apply if you don't have a commensurate, you know, facility in the area. So I am kind of going back in my mind on this, and I am thinking to myself, OK, maybe what I was told originally actually is accurate, that they don't look at prevailing rate, or they didn't look at the prevailing rate in the Wilmington area and looked at other VA facilities elsewhere.

I am just curious. This facility is roughly 85,000 square feet from what I understand. So basically we are paying \$3.50 or so per square foot. This pretty much has all the services that can be provided at a VA facility. Do you know off the top of your head how that compares with another facility elsewhere in the country?

Mr. SULLIVAN. Earlier, I don't know the particulars of that transaction. I will be happy to get it for you. I know as a matter of policy we try and use benchmarking from existing prevailing rates somewhere else with a like facility.

Mr. ROUZER. Now when you say somewhere else with a like facility, where is somewhere else?

Mr. SULLIVAN. Well, in a reasonable area. The contracting officer decides within a reasonable area, is there a comp that is there. And in some cases, as I referenced earlier, there are no comps. I mean, we have places where we put a clinic; there is no healthcare comp anywhere near it. So then they look to see is there an office comp that you can build up off of, and in some cases there might be an office comp and there may not, and they may have to go further away. So it is really market driven.

So I don't think there is inconsistency in the answer because in some cases we have straight comps; you can use them. Others you have an office comp that you build up, and others you will have to go further away. But I don't know the particulars in that case, and we will just have to get it to you.

Mr. ROUZER. Well I have to say for the record it is been very, very difficult for my office to get any transparency at all with the VA on this in terms of comparable rates and how this was negotiated, and I would very much appreciate if you all can provide some transparency there, because there are a lot of folks in my district, and rightly so, including myself, that would like to know.

Mr. SULLIVAN. I will take it back to the contracting folks and get them in contact with your office.

Mr. ROUZER. Thank you very much. I yield back.

Mr. BARLETTA. Thank you. I would like to thank you all for your testimony today. Your comments have been helpful in today's discussion.

If there are no further questions, I would ask unanimous consent that the record of today's hearing remain open until such time as our witnesses have provided answers to any questions that may be submitted to them in writing and unanimous consent that the record remain open for 15 days for any additional comments and information submitted by Members or witnesses to be included in the record of today's hearing. Without objection, so ordered.

I would like to thank our witnesses again for your testimony today. If no other Members have anything to add, this subcommittee stands adjourned.

[Whereupon, at 11:49 a.m., the subcommittee was adjourned.]



United States Government Accountability Office

Testimony

Before the Subcommittee on Economic
Development, Public Buildings, and Emergency
Management, Committee on Transportation and
Infrastructure, House of Representatives

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VA REAL PROPERTY

VA Should Better Justify Its Need to Lease Major Medical Facilities

Statement of Rebecca Shea, Acting Director
Physical Infrastructure Issues

Chairman Barletta, Ranking Member Carson, and Members of the Subcommittee:

I am pleased to be here today to discuss our report on the Department of Veterans Affairs' (VA) leasing practices. VA operates the largest health care network in the United States through the Veterans Health Administration, with over 2,700 health care sites, including hospitals and outpatient facilities. However, many facilities are outdated and VA estimates it will need \$63 billion over the next 10 years to address its capital needs. In recent years, VA has increasingly leased space for its medical facilities, including major medical facilities.¹ From 2005 to 2015, the number of VA's leased medical facilities grew by 80 percent to 1,246 facilities and included leases for 57 major medical facilities. VA's major medical facilities provide numerous services such as mental health and other clinical care, are generally built by developers to meet VA and federal-design requirements, can exceed 200,000 square feet, and have an average annual rent in excess of \$1 million. Before it can execute leases for certain facilities, a prospectus must be submitted to Congress for authorization.

My statement today summarizes the findings from our June 2016 report, which examined the factors that account for VA's decisions to lease major medical facilities and the extent to which VA's cost-estimating process for leasing these facilities reflects best practices.² To conduct that work, we reviewed documentation on VA's Strategic Capital Investment Planning process, GAO and Office of Management and Budget (OMB) guidance on capital planning, and GAO guidance on cost-estimating, and reviewed prospectuses for the 51 major medical facilities submitted to Congress for fiscal years 2015 through 2017. We also analyzed data and other documentation on VA's 23 major medical facility leases authorized and completed between fiscal year 2006 and fiscal year 2015, and interviewed VA officials. More detailed information on our scope and

¹VA considers major medical facility leases as those with annual unserviced rent costs of more than \$1 million. Unserved rent includes base or shell rent, real estate taxes and insurance, and excludes all operating expenses and utilities. VA submits its prospectuses for major medical facility leases, which provide the agency's justification for each proposed project, as part of its annual budget submission.

²GAO, *VA Real Property: Leasing Can Provide Flexibility to Meet Needs, but VA Should Demonstrate the Benefits*, GAO-16-619 (Washington, D.C.: June 28, 2016).

methodology can be found in the issued report. Our work was performed in accordance with generally accepted government auditing standards.

Our review resulted in the following findings. First, VA leases major medical facilities to benefit from shorter timeframes to open a facility and to attain flexibility to relocate, but VA has not assessed and provided information to decision-makers on how it has benefited from the flexibility to relocate. Second, VA's cost-estimating procedures for major medical facility leases generally align with our 12 cost-estimating best practice steps and recent changes in VA's approach may improve the quality of VA's estimates.

VA Justifies Leasing to Open Facilities More Quickly and to Obtain Flexibility to Relocate but Does Not Provide Information to Decision Makers Demonstrating the Benefits of This Flexibility

VA prioritizes all proposed capital projects using six major-decision criteria (see table 1), which focus on addressing needs that (1) can demand quick solutions, such as the need to replace an expiring lease that cannot be renewed, and (2) often change, such as demands for veterans' access to care options.³ As such, according to VA officials, leasing is often VA's preferred alternative for major medical facilities because project implementation times are often shorter than the time for constructing a federally-owned facility and leasing can provide flexibility to relocate in the future to meet changes in VA's needs.

³According to VA officials, the weightings of these decision criteria are subject to change based on annual evaluations of department-wide priorities. Each criterion also includes several sub-criteria.

Table 1: VA's Criteria for Evaluating and Prioritizing Capital Projects for Fiscal Year 2016, in Order of Priority Weight from Most to Least Weight

Decision criterion	Priority weight	Description
Improve safety, security, and compliance	.324	Improving compliance with safety (e.g., seismic) and security laws, building codes, and regulations (including patient privacy standards).
Fixing what we have	.216	Managing buildings to minimize the extent to which deficiencies in infrastructure, such as information technology, impact the delivery of benefits and services to veterans.
Increasing access	.206	Increasing access for veterans by reducing the time and distance a veteran must travel to receive the best quality services and benefits and providing adequate patron support structures at VA facilities, such as parking facilities.
Rightsizing inventory	.097	Managing space inventory by removing excess space, building new and renovating existing space in order to provide the highest quality services to veterans at the right time and in the right place.
Ensure value of investment	.088	Choosing the best value solution to meeting gaps in care and services.
Departmental initiatives	.069	Aligning projects with department goals, such as reducing energy usage, and VA's strategic plan.

Source: GAO analysis of VA planning documentation. | GAO-16-884T

VA cited a shorter project time frame and flexibility to relocate in all 51 of its prospectuses for major medical facilities' leases submitted to Congress since fiscal year 2015. For example, in the fiscal year 2015 submission, VA cited a shorter implementation time frame and flexibility to relocate as justifications for a new lease in Johnson County, Kansas, to address growing demand and overcrowding at the Kansas City Veterans Medical Center and to reduce the drive time for a high concentration of veterans in the area to within VA's 30-minute drive-time target.

VA also generally identified leasing as the lowest cost alternative in its prospectuses, but in some cases preferred leasing for the two previously cited reasons when other options may have been less costly. For example, in fiscal year 2015, VA proposed a new lease in Lafayette, Louisiana, to replace a facility that the VA determined was too small and estimated leased space would have a total life-cycle cost of approximately \$259 million, compared to \$201 million for construction of a new federally-owned facility.⁴ According to VA, an owned facility would

⁴VA estimated total life-cycle costs in discounted dollars.

require a longer time frame to open than a leased facility and limit VA's flexibility to adapt to potential changes in the veterans population, demand for services, new technologies, or health care delivery.

Leasing may offer VA greater efficiencies and flexibilities when major medical-facility projects are compared to construction. Specifically, VA's use of GSA delegated leasing authority to execute its major medical facility leases requires that VA's lease terms not exceed 20 years.⁵ This period provides some of the flexibility that VA values in terms of relocating to facilities that align with VA's changing needs. Construction of federally-owned facilities may not offer this flexibility given the challenges that we have previously identified with renovating and disposing of some federal properties, including VA's, due to issues such as competing stakeholder interests that can make renovating or closing facilities difficult.⁶ Further, construction of a federally-owned facility requires a full upfront funding commitment that can be difficult to secure in the current budgetary environment. VA officials added that although VA's major medical facility lease projects also generally require a lessor to construct a new facility to VA's specifications, leasing tends to have a shorter project timeframe because it does not require VA to acquire the land on which the facility will be constructed, which can require additional time and resources.

Although VA has justified leasing its major medical facilities to its department leadership and congressional decision makers based on the flexibility that leasing offers compared to other alternatives, VA has not provided these stakeholders with information on the extent to which it has benefited from that flexibility, nor does VA regularly assess information that would help it do so. In particular, while VA regularly cited future "flexibility," such as ability to move when needs change, as a justification for the leases included in its annual capital plans, the benefits that VA has experienced from this flexibility with major medical facility leases are not presented to VA stakeholders responsible for selecting projects to present

⁵According to VA officials, VA currently applies to GSA for delegations of leasing authority to execute all of its leases. GSA may execute leases for terms of up to 20 years. 40 U.S.C. § 585(a)(2).

⁶See GAO, *Federal Real Property: The Government Faces Challenges to Disposing of Unneeded Buildings*, GAO-11-370T (Washington, D.C.: Feb. 10, 2011) and GAO, *Federal Real Property: Progress Made in Reducing Unneeded Property, but VA Needs Better Information to Make Further Reductions*, GAO-08-939 (Washington, D.C.: Sept. 10, 2008).

to Congress or to congressional decision makers. VA officials told us that VA's data systems do not provide VA staff responsible for planning new leases with information on the use of flexibilities with existing major medical facilities' leases, such as how far VA has moved from a previously occupied medical facility and why it has moved to new leased locations. We and OMB have previously identified the importance of assessing the results of capital decisions and incorporating lessons learned from those assessments into capital decisions.⁷ Without transparency on the actual benefits VA has experienced from leasing its major medical facilities, VA and congressional decision-makers may lack information to make informed decisions about the need for VA's major medical facility leases. Further, greater transparency could help decision-makers and taxpayers understand the value of leasing in cases in which VA proposes leasing major medical facilities when other alternatives, such as construction of a federally-owned facility, may have a lower cost.

In our issued report, we recommended that the Secretary of Veterans Affairs annually assess how VA has benefited from flexibilities afforded by leasing its major medical facilities and use information from these assessments in its annual capital plans in order to enhance transparency and allow for more informed decision making related to VA's major medical facility leases. VA agreed with our recommendation, noting that assessing and explaining the benefits and flexibilities of leasing major medical facilities could improve transparency. VA agreed to add this information to future annual budget submissions.

⁷GAO, *Executive Guide: Leading Practices in Capital Decision-Making*, GAO/AIMD-99-32 (Washington, D.C.: Dec. 1, 1998) and Office of Management and Budget, Supplement to Circular No. A-11: *Capital Programming Guide* (Washington, D.C.: June 2015).

VA's Cost Estimating Process for Major Medical Facility Leases Aligns with Most of Our Best Practice Steps and Recent Changes May Improve VA's Estimates for These Leases

VA's cost-estimating procedures for major medical facilities' leases generally align with 9 of the 12 best practice steps for cost-estimating that we have previously identified,⁸ and recent changes may improve the quality of VA's cost-estimating process for these leases. (See fig. 1.) For a cost-estimating process to support the creation of reliable cost estimates, it should substantially or fully meet each of the four characteristics in GAO's Cost Guide—comprehensive, well-documented, accurate, and credible—based on the extent to which the procedures incorporate the underlying best practice steps for each characteristic. We found that VA's cost-estimating procedures for major medical leases fully met the comprehensive characteristic, substantially met the well-documented characteristic, and partially met the accurate and credible characteristics.

Figure 1: Cost-Estimating Best Practice Steps Aligned with Characteristics of High-Quality Estimates

Characteristic	Best practices	Assessment
Comprehensive	Develop estimating plan	Fully met
	Determine estimating structure	Fully met
Well-documented	Define estimate's purpose	Fully met
	Define program characteristics	Fully met
	Identify ground rules and assumptions	Substantially met
	Obtain data	Substantially met
	Document the estimate	Fully met
	Present estimate to management for approval	Fully met
Accurate	Develop point estimate and compare to an independent cost estimate	Substantially met
	Update estimate to reflect actual costs and changes	Partially met
Credible	Develop point estimate and compare to an independent cost estimate	Substantially met
	Conduct sensitivity analysis	Partially met
	Conduct risk and uncertainty analysis	Minimally met

Fully met: Completely satisfied the best practice

Substantially met: Satisfied a large portion of the best practice with only minor issues

Source: GAO analysis of U.S. Department of Veterans Affairs data. | GAO-16-884T

Partially met: Satisfied about half of the best practice

Minimally met: Satisfied a small portion of the best practice

⁸GAO, *GAO Cost Estimating and Assessment Guide: Best Practices for Developing and Managing Capital Program Costs*, GAO-09-3SP (Washington, D.C.: March 2, 2009).

Our finding that VA's cost-estimating process partially met the characteristics for producing reliable cost estimates is based on the following:

- **Comprehensive:** VA's cost-estimating process fully met the comprehensive characteristic because its procedures include both the best practice steps of developing an estimating plan and determining the estimating structure.
- **Well-documented:** VA's process substantially met the well-documented characteristic because its procedures incorporate a large number of related best-practice steps, such as defining the estimate's purpose and presenting the estimate for approval.
- **Accurate:** VA's process partially met the accurate characteristic because the procedures incorporate some elements of the two associated best practice steps. Specifically, VA's process includes the best practice step of developing a point estimate and comparing it to an independent estimate, which is based on the market rental rate determined by a market survey that VA conducts and the cost of specific improvements required for VA's intended medical purposes. VA applies several standard and variable adjustments to the market rental rate to determine the rental portion of the estimated first-year lease cost to include in the VA's prospectuses to Congress. (See Table 2.)

Table 2: VA's Adjustments to Market Rental Rates to Estimate Lease Costs

Adjustment	Description
Delineated market	A variable adjustment to account for the difference between the age, condition, and location of the properties identified by a market assessment within a delineated area and what VA plans to lease. For example, an otherwise comparable property may be older, or in a more or less desirable location. This adjustment takes these differences into account.
Insurance and taxes	A variable adjustment to account for estimated insurance and property taxes VA would pay for a lease. These amounts vary by location.
Conversion of space to VA medical use	A standard 35-percent adjustment to account for the conversion of shell space to VA-specific medical use.

Adjustment	Description
Physical security and sustainability	A standard \$3 per net usable square foot adjustment to account for federally-mandated and VA-required standards for security and sustainability features. The percentage of the square-foot cost that this standard adjustment represents can vary greatly. For example, if the prospectus usable square foot rental rate is \$15, the \$3 charge would represent 20 percent of it, whereas if that rent rate were \$100, it would represent just 3 percent of it.
Conversion of market rates	A standard 15-percent adjustment to convert rentable square foot rates to usable square foot rates—the latter of which being the standard used by VA.
Escalation rate	A variable adjustment, applied after the above adjustments, to account for inflation and market fluctuation between the time of the proposal and estimated year of facility acceptance.

Source: GAO analysis of VA and GSA documentation. | GAO-16-884T

This best practice step normally includes comparing the estimate to an independent cost estimate, which VA does not obtain. Because of the standardized nature of the adjustments to the rent rate and pricing for improvements for major-medical facilities' lease cost estimates,⁹ obtaining an independent cost estimate for these inputs would likely yield little new information; accordingly, we consider the rating for this best practice step to be substantially met. The procedures also include updating the estimate, another best practice step supporting this characteristic, but VA does not update it with actual costs as the best practice step requires. Estimates are updated during the development process to calculate whether actual costs are likely to rise more than 10 percent above the prospectus-estimated cost.¹⁰ For leases executed under GSA authority, the estimated maximum cost provided in a prospectus may be increased for construction or alterations but may not exceed 10 percent.¹¹ After leases are executed VA does not update the estimate with actual costs. Updating the estimate with actual costs is a best practice step because it

⁹We did not review the suitability of the standard and variable adjustments VA applies.

¹⁰To calculate whether actual costs may rise more than 10 percent above the prospectus-estimated cost, the prospectus estimate is first multiplied by a standard rate, called an escalation factor, for each year between prospectus authorization and VA's likely acceptance of the facility from the developer at completion. This adjusted rate is compared to the awarded lease rate to determine if congressional approval is necessary.

¹¹40 U.S.C. § 3307.

enables a "lessons learned" analysis, which can strengthen estimates going forward.

- **Credible:** VA's process partially met the credible characteristic because VA's procedures incorporate some elements of the three associated best practice steps. For example, the best practice step of conducting a sensitivity analysis on the lease's cost estimate is not directly included in VA's procedures, but some procedures do address uncertainty and risk. A sensitivity analysis reveals how to assess the potential variability in the estimate by calculating how the estimate is affected by a change in any single underlying assumption. These calculations identify the cost elements that represent the most risk to an estimate. Instead, VA officials said that VA applies an annual escalation rate¹² to adjust for increases in market rental rate and inflationary increases in the cost for tenant improvements over time.¹³ two key assumptions supporting the estimate that could cause actual first-year lease costs to fluctuate from the prospectus estimated costs. We found that VA's use of an escalation rate often did not fully account for variation in lease costs. Specifically, our review of cost data provided by VA for 18 of the 23¹⁴ most recently completed major medical-facility leases activated by the end of fiscal year 2015 shows that actual costs for 15 of the 18 leases varied substantially from adjusted prospectus costs, including 7 leases that were more than 15 percent above VA's adjusted estimates and 8 that were more than 15 percent below the VA's adjusted estimates.¹⁵ For example, actual first-year lease costs increased about 26 percent over the adjusted estimate for VA's San Francisco, California, medical facility's lease

¹²Through fiscal year 2015 the escalation rate was 4 percent, but VA adjusted this amount to about 2 percent for fiscal year 2016 to align with GSA's escalation factor.

¹³The escalation rate is applied to estimate costs every fiscal year from prospectus authorization through facility acceptance.

¹⁴Five leases in our population accounted for their lump sum payments at facility acceptance differently than the other 18, so these leases were excluded from our calculations.

¹⁵"Adjusted prospectus costs" include the 4 percent escalation rate applied to rent (and not to tenant improvement costs) for each fiscal year between prospectus approval and facility acceptance. "Actual costs" include first-year shell rent and lump sum payments for tenant improvements to bring the facility up to par with standards for VA medical space that are listed in the supplemental lease agreement signed when VA accepts the facility from the developer.

and decreased about 44 percent for the VA's Montgomery, Alabama, facility.

VA recently issued a new standard design guide to increase the reliability of its prospectus estimates for major medical facilities and plans to conduct a "lessons learned" study that could further improve how VA estimates its costs. The standard design guide, issued in January 2016, covers the different types of outpatient clinic facilities and provides guidance on VA activities, such as site selection, and delineates minimum federal-facility requirements for security, sustainability, and seismic standards. VA officials told us that the new guide was developed to reduce the risk of facility changes and consequent cost changes for lease projects, and that moving forward all authorized major medical facility leases would use this guide. Reducing the potential for design changes—which we have previously found to be a main driver of increases in facility costs¹⁵—after a prospectus is submitted may enable VA to better estimate facility costs. Second, VA officials told us that the department is planning a "lessons-learned" review that would involve updating data used for planning major medical facilities' leases with actual cost data after the facility is accepted. This type of review can improve cost-estimating processes over time by exposing the precise reasons why actual costs differed from the estimate, such as faulty project ground rules and assumptions, and previously unrecognized risks. The new design guide and the lessons-learned study are in the early stages, and their success will depend on how quickly and successfully VA implements them.

In conclusion, the recent changes in VA's leasing program show promise for improving cost estimates for VA's major medical facility leases. In particular, VA's new guidance could introduce more discipline into the process and VA's "lessons learned" study could identify factors that lead to cost variance from what is proposed to Congress. Further, VA's commitment to assess and provide information to Congress on the benefits and flexibilities of leasing major medical facilities could provide much needed transparency to VA's decisions to pursue leasing versus other alternatives. We will continue to monitor how VA proceeds with these changes.

¹⁵GAO, *VA Real Property: Action Needed to Improve the Leasing of Outpatient Clinics*, GAO-14-300 (Washington, D.C.: April 30, 2014).

Chairman Barletta, Ranking Member Carson, and Members of the Subcommittee, this completes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

**GAO Contact and
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Acknowledgments**

If you or your staff members have any questions concerning this testimony, please contact Rebecca Shea, (202) 512-2834; shear@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions include Heather MacLeod, Assistant Director; Jennifer Echard, Delwen Jones, James Leonard, and Crystal Wesco.

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**STATEMENT OF
JAMES M. SULLIVAN
DIRECTOR OF THE OFFICE OF ASSET ENTERPRISE MANAGEMENT
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
HOUSE COMMITTEE ON TRANSPORTATION & INFRASTRUCTURE
SUBCOMMITTEE ON ECONOMIC DEVELOPMENT, PUBLIC BUILDINGS
AND EMERGENCY MANAGEMENT**

September 28, 2016

Good morning, Chairman Barletta, Ranking Member Carson, and Members of the Committee. Thank you for the opportunity to appear today to discuss the Department of Veterans Affairs (VA) leasing program, which is an integral part of our ongoing mission to care for our Nation's Veterans. VA continues to develop its real property portfolio through the provision of state-of-the-art facilities that meet the needs of Veterans and allow for the highest standard of service. VA is committed to improving its internal leasing practices, as outlined in the Government Accountability Office's (GAO) report on VA Real Property, and its partnership with the General Services Administration (GSA), so VA can meet increased workload demands, further advances in medicine, adhere to evolving Federal requirements, and offer services closer to where Veterans live. Congress can help VA deliver timely and exceptional care to Veterans by authorizing the 24 major medical leases that are pending congressional action.

VA Strategic Objectives

One of VA's strategies, as stated in the Department's fiscal year (FY) 2014-2020 Strategic Plan, to improve access and quality of care is to build a flexible and scalable infrastructure through improved organizational design and enhanced capital planning. The size of the Veteran population may be decreasing, but the demographics and

preferences are increasing in complexity. VA's infrastructure – organizational structure, equipment, and facilities – must continue to be flexible and scalable in order to better serve Veterans of today and tomorrow.

As outlined VA's FY 2014-2020 Strategic Plan, VA continues capital planning efforts to provide safe, secure, modern, and sustainable infrastructure, and enhance capital planning efforts that increase the flexibility of VA's capital infrastructure to accommodate integration of services and promote sharing of physical and virtual space within and between VA and its partners. VA is also expanding virtual or "connected" health benefits and services, which may reduce our dependency on physical infrastructure.

VA Real Property Portfolio

VA is the owner, tenant, and operator of one of the largest health care real estate portfolios in the United States. In addition to real estate holdings for the provision of health care services, the Department maintains facilities for the Veterans Benefits Administration (VBA) and national cemeteries that are under the management of VA's National Cemetery Administration (NCA). Leasing has been and continues to be an essential strategy for VA's capital portfolio management and is an important tool that allows VA to develop infrastructure and provide services where Veterans need it most. Leasing allows VA to quickly and effectively adapt its infrastructure to accommodate for changes in medical technology, workload (both inpatient and outpatient), new programs that assist Veterans, and ever-shifting demographics. Leasing provides flexibility and allows VA to respond quickly when and where a need arises.

Overall, VA maintains approximately 155 million square feet in 6,300 owned buildings and more than 33,000 acres of land. Approximately 25 million square feet of space has been acquired through over 1,968 leases for the Department -- ranging in term length from a few months to 20 years. VA's portfolio of nearly 180 million square feet is one of the largest in the Federal Government.

Lease Delegation Authority

VA, through authority that is delegated on a project-by-project basis by GSA, enters into lease agreements for medically-related space or infrastructure needs in locales across the Nation and largely relies on GSA for procurement of all non-medical space. VA does not have the direct authority to procure leases for terms of up to 20 years while obligating on an annual basis, so the Department relies on its partnership with GSA to obtain individual delegations to make operating leases feasible. VA works closely with GSA under the lease delegation process and is able to leverage GSA's authority to meet the needs of our Veterans.

VA's Mission Needs

VA's mission represents the driving force in the Department's use of leasing to acquire space. Leasing enables VA to locate services where needed and adjust to changes in the health care delivery landscape in order to meet the constant demographic shifts and changing service demands of our Nation's Veterans. One of VA's primary goals achieved through leasing is the provision of access points for service where Veterans are located. Veterans are mobile and have evolving health care needs, which requires VA to respond quickly when and where a need arises. Leasing provides more flexibility, in lieu of constructing owned assets. There are shorter time frames to execute leases and leasing provides VA maximum flexibility to efficiently adjust its infrastructure to meet current and future needs.

GAO 2016 Leasing Report

GAO's June 2016 report, "VA Real Property: Leasing Can Provide Flexibility to Meet VA needs, but Should Demonstrate the Benefits" stated that "the Department of Veterans Affairs leases major medical facilities to benefit from shorter time frames to open a facility and to attain flexibility to relocate. These factors may help VA to meet its

needs, such as improving facility compliance with standards and increasing Veterans' access to care and services." As stated in VA's June 14, 2016, response, the Department is pleased that GAO recognizes the important need for medical leasing and the flexibility that leasing provides. As stated in the report, leasing also allows VA to align with changing health care needs. The report highlights the improvements that VA has made while operating under the GSA lease delegation processes and suggests that other agencies implement similar processes. GAO's report also acknowledges that VA has a documented process in place to estimate lease costs and explain those costs.

GAO's recommendation stated that VA needs to assess the benefits of major medical leasing and that VA should use that information in the annual budget submission. VA agrees that it is important to provide this information and concurred with the recommendation. To address the recommendation, the Department will further document why major leasing is chosen as the preferred option to obtain facilities for Veterans and will state the benefits gained by VA and Veterans. This information will be presented in future annual budget submissions as part of the published Strategic Capital Investment Planning (SCIP) process long-range plan.

VA's Strategic Capital Investment Planning (SCIP) Process and Lease Costs

Since 2012, the need for leased space to support VA's mission in a particular location is identified through the SCIP process. The SCIP process enables VA to improve the quality, access, and cost efficiency of the delivery of VA benefits and services through modern and relevant infrastructure that matches the location of current and future demand. As an integral part of the SCIP process, VA systematically evaluates all proposed capital investments, including leases, based on how well the proposals address identified performance gaps (e.g., safety, security, workload-driven capacity shortage, right-sizing, and access for Veterans). These gaps specify where current infrastructure or services need to be enhanced to meet the location and demand of current and future Veteran demographics or where VA may have excess capacity.

Only those capital investment projects that have scored well in addressing identified performance gaps are proposed for funding in VA's budget.

In line with the SCIP process, VA evaluates the decision of whether to build or lease. Projects considered for leasing are required to provide an "alternatives analysis" that considers the status quo, new construction and/or renovation, leasing, and contracting out for services. Review of the alternatives analysis is a critical part of the decision-making process and assists in ensuring the most efficient and effective use of taxpayer's dollars. The major medical lease prospectuses found in VA's budget submission provide the alternatives considered (major construction versus leasing) as well as justification for the chosen alternative.

VA considers the size and mission criticality of a project when deciding between building or leasing a new facility. In most cases, it is more cost effective to build than lease for large inpatient and specialty care projects over a 30-year building lifecycle. However, in many cases, outpatient and ambulatory services can be done more efficiently using leasing, as leasing provides more flexibility in occupancy terms and in executing an exit strategy. The ability to provide services as close as possible to the Veteran population is the key driver in all capital decisions. Ultimately, the cost to obtain leased space is driven by the market. VA competitively bids leases and actual rental rates are determined through full and open competition. The rates are also validated by fair market value assessments or independent cost estimates prior to lease award. VA also works with GSA to ensure all leases meet the operating lease requirements per Office of Management and Budget Circular A-11, Appendix B, including the requirement that "the present value of the minimum lease payments over the life of the lease does not exceed 90 percent of the fair market value of the asset at the beginning of the lease term."

Leasing Process Improvements

In order to better align with the GSA lease delegation process, VA has implemented a series of improvements to its leasing processes. Many of these improvements were acknowledged by GAO. VA has worked to align building requirements to private sector health care industry specifications, while continuing to meet Federal minimum occupancy standards. VA pays for non-recurring enhancements and Government-specific features upfront, instead of spreading it out over the lease term. VA is also implementing standardized clinical design prototypes to reduce timeframes for preparing conceptual designs for VA clinics. VA has also implemented a thorough internal peer review process to ensure that complete and accurate delegation requests are submitted to GSA. VA continues to identify opportunities to improve the leasing process and is open to suggestions for ways to better serve Veterans.

Future Leasing Plans

VA plans to continue leasing facilities as an efficient means to serve Veterans. The Department has 24 major medical leases that are pending Congressional authorization, many of which were originally submitted to VA's authorizing committees almost 3 years ago. The pending major medical facility lease projects will replace, expand, or create new outpatient clinics and research facilities and are critical for providing approximately 2.7 million appointments for Veterans annually and enhancing our research capabilities nationwide. Without authorization from Congress, VA cannot begin work to secure needed leased space to meet the needs of Veterans seeking VA healthcare. Failure to receive authorization will have a growing, and worsening effect on Veteran access to care nationwide, as leased VA medical facilities may be forced to close and new and/or expanded facilities may not open.

Once authorizations are received, VA will begin working with GSA to obtain delegations and also begin the process to execute the leases. Additionally, this committee will soon receive eight VA leases for resolution. These leases were authorized by the Veterans Access, Choice, and Accountability Act of 2014; however

they exceed the GSA Prospectus threshold and therefore require Committee authorization by resolution. Once the resolutions are passed and GSA is provided the authority to grant delegations for the eight leases, VA will be able to move forward with the solicitation process to procure the needed space. The Department is also in the process of identifying new and replacement lease projects through the SCIP process for inclusion in VA's FY 2018 budget request. In line with GAO's recommendation, VA will implement improvements to the lease prospectus for beginning with the FY 2018 budget request.

Conclusion

VA understands it has the responsibility to manage all projects efficiently and to be a good steward of the resources entrusted to VA by the American people. VA continues to modify leasing procedures and planning processes resulting in the improved execution of leasing projects. VA will continue to enhance its leasing processes by identifying and addressing any organizational, policy, or procedural constraints that limit our ability to develop cost-effective, medical facility leases.

The Department also bears the sacred responsibility to provide timely and exceptional care to our Nation's Veterans. We have taken on the challenge of updating our aging infrastructure to allow for flexibility to meet increased workload demands; changing Veteran patient demographics; advances in medical technology; new complex treatment protocols and advanced procedures; and deliver patient-centered care expeditiously. The 24 leases pending authorization are a part of VA's plan to update our aging infrastructure. If Congress fails to provide lease authorizations for the 24 pending leases - some dating back to fiscal year 2015 requests - VA's ability to provide Veterans with timely and exceptional care will be impeded.

VA will continue enhancing its partnership with GSA to ensure that through the delegation process, VA is able to continue leasing space to serve Veterans. VA will also continue to meet with Congressional delegations to discuss these projects to keep them

apprised of the status, including regular updates to the Congressional Committees to ensure they are fully informed of the progress of VA's lease projects. We are eager to work with Congress to ensure all necessary major medical leases are authorized so VA can improve the timely delivery of exceptional medical care.

Mr. Chairman and Members of the Committee, this concludes my statement. Thank you for the opportunity to testify before the Committee today. I would be happy to respond to any questions you may have.

Answers to Questions for the Record
“Department of Veterans Affairs Leases: Is the VA Over-Paying for Leased Medical Facilities?”

Subcommittee on Economic Development, Public Buildings, and Emergency Management Hearing
U.S. House of Representatives

Wednesday, September 28, 2016

Questions for the Record for Mr. James M. Sullivan

Submitted on behalf of Congressman Mark Meadows:

Department of Veterans Affairs Leasing

- 1. Why do you want to use leasing when you’re building to suit? How is it a benefit to those being leased?**

VA Response: Leasing enables the Department of Veterans Affairs (VA) to more quickly respond to health care advances and adopt changing technology in order to provide state-of-the-art health care to Veterans. Leasing provides flexibility to help address the constant challenge to keep up with the ever changing pace of medical advancement. Leasing also provides flexibility to rapidly adjust to current and future demographic shifts and changing service demands.

More specifically, leasing permits VA the ability to move from facilities at the end of a lease, while having no responsibility for aging infrastructure or costs associated with the disposition of real property. Leasing also allows VA to more efficiently manage budget concerns, as construction would require VA to allocate funding for the entire cost of the construction upfront. Moreover, construction of a build-to-suit lease is often quicker than a government construction project. In a government construction project, the procurement process typically requires the involvement of several different firms to provide architectural/engineering as well as construction services. These services typically require a separate procurement causing an increase in the amount of time associated with completion of the project. Once construction is completed, the government bears the responsibility of maintaining the owned asset which requires the outlay of funds, time, and personnel resources. Even when the asset is no longer in use or functional, the government bears costs associated with keeping the asset running and secured until such time the asset is finally disposed.

Conversely, by acquiring a build-to-suit lease, the government procurement process moves more quickly and more fluidly because construction timeframes are often faster in the private sector and the government typically deals with only

one firm (the lessor). Also, upkeep of a massive real estate portfolio is already a significant challenge for VA. With medical technology changing quickly, VA's capital needs also change—and leasing provides a flexible alternative to construction. Should the government no longer have a need for the asset—for example, due to the changing demographics of the Veteran population—the government bears the responsibility of disposing of the owned asset. Disposal also requires additional outlays of funds, time, and personnel resources; these resources could be redirected toward serving our Veteran community.

- 2. If the cost of the lease covers the entire cost of construction and the residual value is zero, what is the public benefit? Are you leasing at less than the full cost of the build to suit?**

VA Response: The cost of construction is not covered entirely by the costs of the lease. Office of Management and Budget (OMB) circular A-11 includes a test to demonstrate that the cost of the lease does not exceed 90 percent of the cost to construct the asset. This test is in place to ensure that the lease makes financial sense for the government. A copy of this test is provided to VA's authorizing committees as required by Public Law 113-146 (the Choice Act) with each Congressional notification package for major lease awards. One benefit of leasing is that it allows construction costs to be spread over the life of the lease. This equates into a greater number of VA facilities to serve Veterans. Another benefit of a leasing project is that the procurement process typically completes earlier than a construction project. Another benefit of leasing is that the lessor bears the responsibility of maintaining the leased space. This degree of continuity is important because any potential concerns with the space can be quickly addressed and resolved by the lessor. In addition, by locking in the lease cost in current dollars spread over 20 years, VA will spend less than if all costs were born in present day dollars up front as would occur in a construction scenario. Lastly, should the government no longer have a need for the leased space; the government can quickly dispose of the asset by simply returning the space to the lessor. This benefits Veterans by eliminating a strain on resources by maintaining outdated or historic assets, and provides additional facilities to increase access for Veterans.

- 3. What analysis have you had from veterans in terms of location; what matrix do you use? How many veterans have you (or your contractors) talked to?**

VA Response: VA engages in thorough and continuous analyses of several factors when planning for Veteran health care delivery in communities. Identifying appropriate locations to site VA health care facilities requires extensive analysis of a multitude of factors. These factors include projected total Veteran population, Veteran enrollee population, and utilization trends over a 20-year planning horizon.

Specifically, VA's Enrollee Health Care Projection Model (Model) projects the number of Veteran enrollees in a geographic area; the total continuum of more than 50 enrollee outpatient and inpatient health care services, including specialty care; the portion of care enrollees are expected to receive in VA versus from other health care providers over a 20-year planning horizon; and population and demand projections, which account for current Servicemembers and new Veterans from recent conflicts (Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn) and include gender-specific health care needs.

Assessment of Veteran health care delivery needs is based on Model projections and on criteria such as existing and planned points of service (both VA and non-VA), access standards, market penetration, cost effectiveness, waiting times, and other unique factors using VHA's Health System Planning Application (HSPA).

HSPA provides a standard 10-step study methodology to proactively evaluate the comprehensive health care needs of Veterans in Veterans Integrated Service Network (VISN) markets, and develop strategies to meet those needs. The HSPA uses a live portal for systematic data analysis. Appropriate data sources are built into the portal to maximize the time VISNs spend in analysis versus data gathering. Identified capital initiatives are inputted into VISN Strategic Capital Investment Planning (SCIP) Action Plans and Strategic Capital Assessments.

VA's thorough and statistically rigorous planning ensures that Veterans receive the highest quality care in the most appropriate locations for inpatient and outpatient services.

4. How many times have you moved or switched locations because of the flexibility other witnesses referenced?

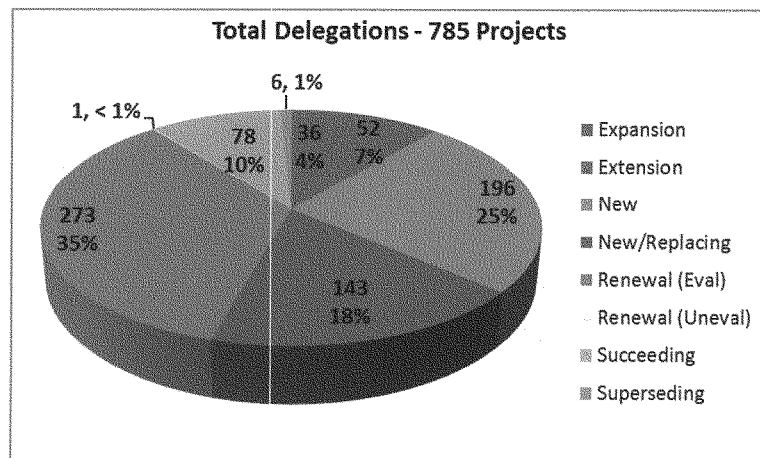
VA Response: In the majority of cases, VA has a change in requirements that necessitates changes in the lease (including both size and/or location). The following tables and charts illustrate the number and types of VA leasing projects that had received a leasing delegation from General Services Administration (GSA) as well as a breakdown of the number and percentage of projects that involved a change in requirements. Between July 2014 and September 2016, GSA approved 785 lease delegation requests from VA for existing and new contract projects.

The initial charts/tables provide an overview of the various types of delegation actions VA has requested from GSA. Those are further broken down into delegation actions involving changes to existing lease contracts versus actions that result in new lease contracts. Further breakdown is provided on the number of delegation actions that resulted from changed requirements that leveraged leasing flexibility to accomplish. While the information can be viewed in multiple ways, the need to move locations or change the scope of a leased facility is

clearly demonstrated in the majority of the delegation requests that involved new contracts.

Table 1/Chart 1:

Delegations Overall By Project Type	# Of Delegations	% of Total Delegations
Existing Lease Contracts		
Expansion	36	5%
Extension	52	7%
Renewal (Eval)	273	35%
Renewal (Uneval)	1	< 1%
Total - Existing	362	46%
New Lease Contracts		
New (New Presence)	196	25%
New/Replacing (Existing Presence)	143	18%
*Succeeding (Existing Presence)	78	10%
Superseding (Existing Presence)	6	0.8%
Total - New	423	54%
Total Delegations/Projects		785

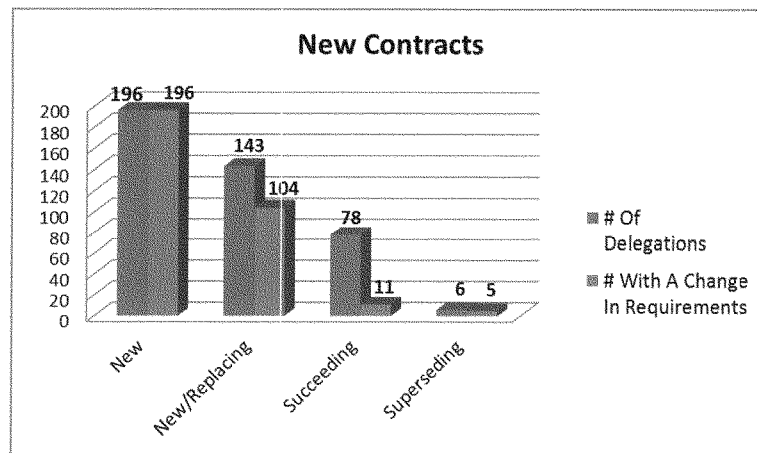


Existing contracts consisted of situations that involved within-scope modifications (expansions) or instances where the lease continued within its original scope (extensions and renewals). Renewals can be both evaluated, meaning the option to renew was evaluated at the time the lease was signed, or unevaluated, meaning the option to renew was present in the lease, but not evaluated at the time of lease award. New contracts consisted of situations where either no lease had existed (new) or where an existing lease was replaced with a new lease (new/replacing, succeeding, or superseding).

Of the 785 delegations, 362 (46 percent) involved existing contracts and 423 (54 percent) involved new contracts.

Table 2/Chart 2:

New Lease Contracts Involving A Change In Requirements	# Of Delegations	# With A Change In Requirements	% Involving A Change
New (New Presence)	196	196	100%
New/Replacing (Existing Presence)	143	104	73%
*Succeeding (Existing Presence)	78	11	14%
Superseding (Existing Presence)	6	5	83%
Total Delegations/Projects	423	316	75%



Existing contracts continue within their original scope, therefore, if there are any changes in scope or requirements, then these would be reflected in a new contract. Of the 423 new contracts, 316 (75 percent) involved a change in requirements.

One subset of new contracts consists of instances where there was a new requirement to provide Veterans services in a specific service area, but no facility existed within the service area. In these cases, VA sought delegations to obtain 196 new leases and 100 percent of these new leases therefore resulted from a change in requirements, in this case a brand new requirement.

The other subset of new contracts consist of replacement contracts, which are instances where an existing lease was replaced with, succeeded by, or superseded by a new lease. In these cases, VA sought delegations to obtain 227 replacement contracts and 120 (53 percent) of these leases involved a change in requirements that necessitated either a new lease scope and/or a move to a new location.

* As can be seen in the two charts, VA has recently requested delegation for a number of succeeding leases. The volume of succeeding leases is higher than VA would typically pursue; however, there is a need for "bridge" leases to continue services in existing locations while larger, long-term lease solutions are brought on line. Given some of the challenges in obtaining the appropriate authorization for VA prospectus level leasing, executing short or mid-term succeeding leases allows VA to continue to provide Veteran services while those longer term solutions work their way through the approval, and ultimately execution, processes. In addition, our Vet Center program has a number of smaller leases that are typically shorter term leases, however location is critical for these lease as they need to be readily accessible to the Veteran population. A number of these Vet Center leases have recently come up for renewal and were pursued as succeeding leases.

Submitted on behalf of Congressman David Rouzer:

Wilmington Veterans Affairs Medical Center

1. **Given that local commercial real estate brokers have acknowledged the Wilmington VA HHC is paying approximately twice the prevailing rate for local prime medical real estate at nearly \$300,000 per month, how does the Wilmington VA HCC price per square foot compare to similar VA facilities' price per square foot in other parts of the country? How does it compare to facilities in markets with similar real estate environments?**

VA Response: The rental costs for the Wilmington Outpatient Clinic are comparable with other leased VA medical facilities of similar size and functionality in the Southeast (north of and excluding Florida). At approximately \$36.80 per net usable square foot (NUSF) unserviced, the rental rate for the Wilmington Outpatient Clinic falls well within average rental rates of awarded major leases meeting the parameters and specifications identified in the Wilmington Outpatient Clinic. These comparable lease rental rates range from the low \$30s to low \$40s per NUSF. At the time of the March 2011 Wilmington

Outpatient Clinic lease award, requirements specific to the Federal Government, such as enhanced physical security and sustainability measures, were captured within the lease rental rate. These costs are now paid by VA in a lump sum payment after the project is acceptable for use and are no longer included in the lease rental rate.

2. **When considering potential real estate for VA health care facilities, which price factor plays a bigger role in lease decisions: the local prevailing market rate or rates for comparable existing VA facilities in other parts of the country? When a contracting officer determines a lease rate to be fair and reasonable, does policy indicate whether prevailing market rates or rates for existing VA facilities are the preferred comparison to the lessor's proposed rate?**

VA Response: VA's lease award determinations are based on the best value procurement methodology outlined within the Solicitation for Offers (SFO), which includes a combination of predetermined technical factors and price. When combined, the technical factors are weighted equally to cost. At the time of this lease award, the rental costs were determined by the competitive offers received for this specific requirement, and was further supported by a rental rate appraisal of VA's requirements. An appraisal takes into account local market rates and comparable facilities. Additional information on whether a rental rate is fair and reasonable is achieved through sufficient competition within the underlying solicitation, which is what occurred in the Wilmington Outpatient Clinic procurement.

3. **If there is not an existing comparable medical facility found during the VA candidate sight examination process, how far with the VA travel geographically from the relevant municipality in search of existing medical real estate that may meet VA specifications? How frequently does the VA conduct this process?**

VA Response: VA's delineated areas in a procurement are determined by the Veteran needs and demographics within each community, and are further refined from a real estate perspective to ensure sufficient competition exists. For many of VA's major leases, such as Wilmington Outpatient Clinic, existing space that can meet VA's needs does not readily exist in the marketplace. At the time of the Wilmington Outpatient Clinic procurement, VA only sought available vacant land to construct a facility. VA's current policy is to consider both existing buildings and vacant land within the delineated area, and this process is conducted on every major lease that VA procures.

4. **Please provide an outline of the Wilmington VA HCC lease search process detailing the methodology the VA used to select the site as well as the factors considered to determine the lease rate.**

VA Response: VA utilized a two-step procurement process for the Wilmington Outpatient Clinic, as was standard practice at the time for build-to-suit leased based medical facilities. Step one involved the selection of a preferred site on which to build the new facility. A preferred site is competitively selected by a market survey team composed of VA employees with experience in various disciplines such as real property, engineering, environmental issues, and clinical or program management. In this case, two alternative sites were selected prior to VA settling on the airport site. The first site was eventually bypassed when the landowner was unwilling to have anyone else develop the property for VA, and due diligence on the second site turned up wetlands that limited development of the site. As such, VA proceeded to enter into an Assignable Option to Ground Lease for the airport site.

Step two was the procurement of a developer to construct the facility and lease it back to VA. This process was conducted as a best value competition where both price and technical factors were evaluated in accordance with the Competition in Contracting Act, the General Services Administration Acquisition Regulation, and the Federal Acquisition Regulation, as well as other applicable laws and executive orders. Every effort is made to obtain the greatest amount of competition during the procurement process to ensure reasonable rental rates. VA considered technical factors such as the architectural concept and building design, operations and maintenance of the facility, as well as past performance and the qualifications of the teams that were put together. An examination of price included a review of the reasonableness of the rental costs, which were determined by the competitive offers received. These rental costs included, within the base rental rate, many features that were specific to the government's requirements as well as the costs for the ground lease with the airport. As noted earlier, requirements specific to the Federal Government, such as enhanced physical security and sustainability measures, are now paid by VA in a lump sum payment after the project is accepted for use and are no longer included in the lease rental rate.

5. **Wilmington NC VA LLC must pay the New Hanover County Airport Authority \$18,000 per month (\$217,000 per year) since the Airport Authority owns the land on which the clinic sits. How was this rate determined? What dollar amount would have ruled out this site?**

VA Response: As noted above, the site owned by the New Hanover County Airport was selected after two alternative sites became unavailable. The ground lease for the land at the New Hanover County Airport was the result of in-depth negotiations between VA and Hanover County following the selection of that location for the clinic. We cannot in hindsight declare a particular rental rate that would have ruled out the site, but note that if VA and Hanover County had not been able to come to mutual agreement on a price, VA would have had to pursue an alternative site to locate the clinic. That would have delayed the provision of services to local Veterans. Also note that VA conducted budgetary scorekeeping

in accordance with OMB Circular A-11 to ensure that the rent paid over the life of the lease (which includes costs associated with the land lease) did not exceed 90% of the fair market value of the asset. VA worked diligently to move the project forward and ultimately bring the facility to fruition to serve Veterans.

Statement of Chris Wisner

**Before the
Subcommittee on Economic Development, Public
Buildings and Emergency Management of the
Committee on Transportation and Infrastructure
U.S. House of Representatives**

**“Department Of Veterans Affairs Leases: Is the VA Overpaying
For Leased Medical Facilities”**

September 28, 2016

Good morning Chairman Barletta, Ranking Member Carson, and members of the Committee. I am Chris Wisner, the Assistant Commissioner for Leasing at the General Services Administration’s (GSA) Public Buildings Service. I appreciate being invited here today to discuss GSA’s efforts to provide cost-effective and suitable leased space for our partner Federal agencies, including the Department of Veterans Affairs (VA).

GSA’s mission is to provide the best value in real estate to government and to the American people. GSA currently manages an inventory of more than 374 million square feet of space. Approximately half of this is leased space, comprising more than 8,302 active leases and 190.8 million rentable square feet across the country. GSA seeks to provide space that assists our partner Federal agencies in achieving their missions while best serving the public interest.

As a part of this Administration’s strategy, GSA works to maximize utilization of the existing federally owned inventory, including reducing GSA’s leased portfolio. By improving utilization of GSA’s inventory, we have saved millions of dollars for our partner Federal agencies and for the public.

GSA’s Leasing Process

GSA works to streamline, standardize, and simplify our leasing processes to minimize the costs associated with acquiring leased space. Overall, GSA’s goal for the leasing program is to make it easier for the real estate industry to do business with the Federal government, to deliver leased space quickly to our partner agencies, and to secure competitive lease rates in our procurements.

GSA uses a comprehensive, deliberative process to deliver space that meets agency mission requirements and secure competitive rental rates, while taking into account public interests such as proximity to public transportation and location in central business districts.

In terms of cost to our partners, we strive to keep leasing costs at or below market levels and have developed comprehensive strategies to do so. We use standard industry benchmarks, published market sources, and local expertise to ensure that we get the best value for our customers.

GSA's Prospectus Process

GSA's prospectus process starts with requirements development, where GSA works with customer agencies to define their space needs. As part of the Administration's goal to maximize the use of existing Federal assets and eliminate unneeded and excess real estate, GSA first looks to the existing Federal inventory of owned and leased space to meet those needs. If existing space is not available, GSA determines whether federal construction or leasing is the appropriate space delivery method that balances the mission needs of the customer, market parameters, resource constraints, and fiscal responsibility to the public.

If leasing is the chosen alternative, GSA continues to work with partner agencies to further define its program of requirements. As with owned properties, the program of requirements for a lease includes a comprehensive housing plan, identification of delineated area, and estimated space utilization rate. The prospectus process also requires market research to establish market-based rental rates. GSA conducts its procurements using prevailing market rates as the benchmark for the evaluation of competitive offers to ensure that lease rates are in line with the private sector. The result of this thorough process is submittal of a prospectus and supporting documentation for projects over the threshold¹ that propose the best solution for a validated Government need.

VA Delegation Authority

One of the ways GSA supports customer agencies in acquiring needed lease space is through the delegation of GSA's real property authority by the Administrator of GSA to other Federal agencies. As GSA's core leasing expertise is general office and warehouse space, GSA has a history of delegating authority² to enable Federal agencies to acquire space to meet their mission needs. In 1996, the GSA Administrator granted all Federal agencies conditional delegations of leasing authority to procure general office type space³. Standing delegated authority exists for all Federal agencies for certain categorical space delegations,⁴ and for special purpose space⁵.

In 2007 and 2013, based on feedback from both the Government Accountability Office and the GSA Inspector General, GSA completed comprehensive reviews of the delegations program and

¹ 40 U.S.C. § 3307

² 41 CFR 102-72.30

³ 41 CFR 102-72.30(b)

⁴ 41 CFR 102-73.155

⁵ 41 CFR 102-73.160

modified the overall management of the delegations program for general office, categorical, and special purpose space.

The standing delegations of authority, inclusive of categorical and special purpose space, are explicitly restricted to below the prospectus threshold. Any delegation of leasing authority over the prospectus level is outside the scope of these standing delegations and must be addressed individually.

GSA's Delegated Leasing Authority to VA

In 2014, VA began relying exclusively on GSA's delegated authority to conduct its leasing activities. Some VA requests for delegated leasing authority are above the GSA prospectus threshold, and GSA will submit prospectuses to this Committee and to the Committee on Environment and Public Works of the Senate.

The initial delegation requests from VA required a number of revisions to comply with GSA delegation program requirements, both in form and substance. Furthermore, as delegation requests above the GSA prospectus threshold were not within the normal delegation program management, there was no standing GSA processes for consideration, requesting, and granting such authorization. GSA and VA have worked together to ensure that documents GSA receives from VA are in line with like GSA prospectus submissions to Congress.

Choice Act

GSA supports VA's mission to provide assistance to veterans and their families. From June 2014 to September 2016, GSA has granted VA 761 lease delegations, of which 96% have been granted routinely under GSA's standing delegation program. Only four percent (4%), or 27 of those delegated leases, have exceeded the 19,999 usable square footage (USF) limitation on the standing delegation and have required an individual action by the GSA Administrator. Only six of those requests also exceeded the \$2.85 million prospectus threshold.

The Choice Act, enacted in 2014, provides new authorities and funding to continue VA's mission, including statutorily authorizing the Secretary of Veterans Affairs to carry out leases for 27 VA medical facilities in 18 states and Puerto Rico. Out of these 27 leases, there are eight remaining that are above GSA's prospectus threshold. The Committee's help is needed in providing GSA with resolutions for those projects. As indicated above, GSA will submit those prospectuses to this Committee in upcoming weeks.

Future Planning

As we move forward in our partnership, VA and GSA are working closely to ensure VA projects comply with GSA policies and practices. For instance, as mentioned earlier, GSA has a solid methodology for determining market rental rates, but currently, our methodology does not

provide for clinical or hospital rates. With VA's expertise, and the addition of third party sources of data we have jointly identified, we can bring the same discipline and structure to the market rate justifications for VA prospectuses that we provide for GSA prospectuses.

GSA will also work with VA to continue to refine a hospital cost model, adding to VA prospectuses the same consistency in cost analysis as that found within GSA prospectuses. Furthermore, as part of strategic planning, VA and GSA have an opportunity to identify opportunities for VA to backfill existing underutilized or vacant space instead of initiating new leasing actions.

As this Committee is aware, GSA is committed to earlier upfront planning with our partner agencies to avoid costly extensions and holdovers, and to provide ample time for maximum competition. In that vein, we also stand willing and able to help VA plan and develop future prospectus submissions to ensure compliance with this Committee's expectations.

Conclusion

Chairman Barletta, Ranking Member Carson, and members of the Committee, GSA is dedicated to meeting the requirements of all of our partner agencies in an efficient, transparent, and user-friendly manner. We are committed to streamlining the leasing process and delivery of our projects by constant evaluation of our performance and by incorporating new technologies and approaches to improve efficiency. We will continue to support VA in their mission of providing assistance to veterans and their families. Thank you for the opportunity to testify before you today, and I am happy to answer any questions.